PRINCETON SPORTS & FAMILY MEDICINE

Date: ______________________________
Patient's Name : _____________________
Date of Birth : _______________________

Medical History and Systems Review

Age: ___ Sex: M | F Occupation: ___________ Referring Physician: ___________________________

Date of injury or most recent episode of pain: ________________ Date of surgery: _________________

When is your follow up appointment with your physician: ______________________________________

Briefly describe how the injury occurred: ____

Have you had any previous or similar problems? ____

Is this a work or motor vehicle accident-related injury (Please circle)? YES | NO

What activities aggravate your symptoms? ____

What eases your symptoms? ____

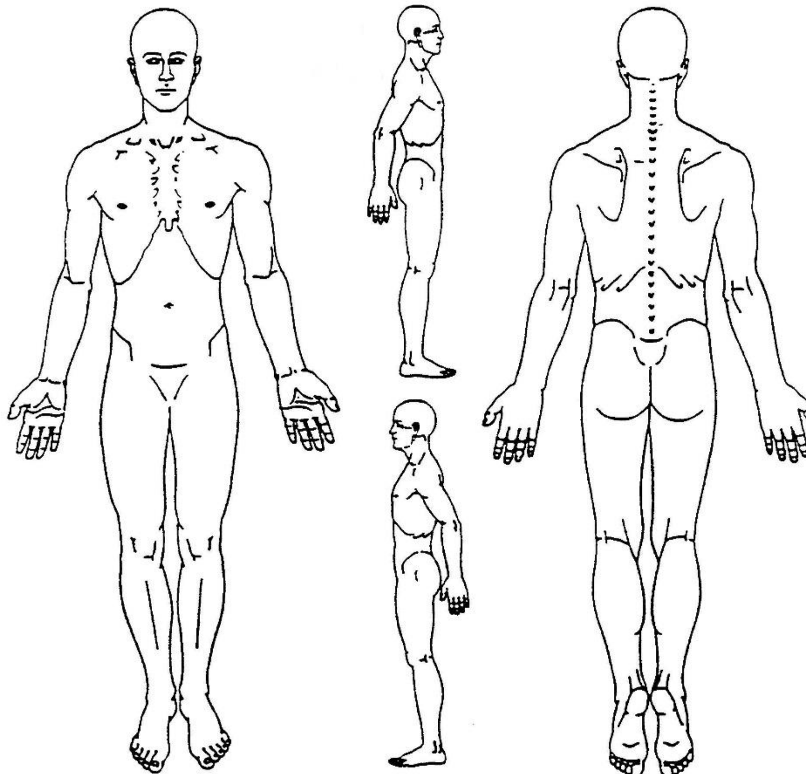
Leisure activities/ hobbies: ____

What are your goals for physical therapy? ____

In the diagram below, please circle involved areas of the body and check all options that apply

Chief Complaints:

- ○ Pain
- ○ Soreness
- ○ Swelling
- ○ Stiffness
- ○ Locking
- ○ Instability
- ○ Weakness
- ○ Numbness / tingling



Types of pain:

- ○ Sharp
- ○ Burning
- ○ Spasm
- ○ Dull
- ○ Radiating
- ○ Achy
- ○ Numbness / tingling
- ○ Fatigue
- ○ Other

Duration of pain:

- ○ Constant
- ○ Intermittent
- ○ During rest
- ○ During activity
- ○ Following activity
- ○ Night pain

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Are you currently under another physician's/health professional's care at this time? If so, please indicate:

- ☐ Medical Doctor (MD)
- ☐ Doctor of Osteopathy (DO)
- ☐ Physical Therapist
- ☐ Athletic Trainer
- ☐ Psychiatrist/Psychologist
- ☐ Other ____________
- ☐ Chiropractor
- ☐ Podiatrist
- ☐ Acupuncturist

Have you had any of the following test for this condition? If so, please indicate:

- ☐ X-Ray
- ☐ MRI
- ☐ Bone Scan
- ☐ CAT Scan
- ☐ EMG/NCV
- ☐ Other ____________
- ☐ Ultrasound
- ☐ Doppler

During the past 2 weeks, have you taken any of the following over-the-counter medications? If yes, please indicate:

- ☐ Aspirin
- ☐ Advil | Ibuprofen | Motrin
- ☐ Antihistamines
- ☐ Herbal Medications
- ☐ Decongestants
- ☐ Other ____________
- ☐ Tylenol
- ☐ Vitamins
- ☐ Antacids

Please list any prescriptions medications:

____

Are you allergic to latex? ☐ YES ☐ NO

Please list any additional allergies: ____

Do you drink alcohol? ☐ YES ☐ NO If yes, approximate how much each day?____________

Do you smoke? ☐ YES ☐ NO If yes, approximately how many packs a day? ________

Have you ever been diagnose as having any of the following conditions? If so, please indicate:

- ○ Anemia
- ○ Asthma
- ○ Blood Clots
- ○ Cancer
- ○ Chemical Dependency
- ○ Circulation Problems
- ○ Concussion
- ○ Depression
- ○ Diabetes
- ○ Dizziness
- ○ Emphysema
- ○ Epilepsy
- ○ Fibromyalgia
- ○ Headaches/ Migraines
- ○ Heart Disease
- ○ Hepatitis
- ○ High Blood Pressure
- ○ HIV
- ○ High Cholesterol
- ○ Kidney Disease
- ○ Lyme's Disease
- ○ Multiple Sclerosis
- ○ Osteoarthritis
- ○ Osteoporosis
- ○ Parkinson's
- ○ Pregnant or think you may be pregnant
- ○ Rheumatoid Arthritis
- ○ Stomach Ulcers
- ○ Stoke
- ○ Thyroid problem (Hyper | Hypo)
- ○ Tuberculosis
- ○ Other

Have you recently experience any of the following? If so, please indicate

- ○ Fever/Chills/ Sweats
- ○ Unexplained weight loss/ gain
- ○ Fatigue
- ○ Nausea/Vomiting
- ○ Weakness
- ○ Numbness/Tingling
- ○ Shortness of breath
- ○ Night pain/Loss of sleep
- ○ Bowel/ Urinary Problems
- ○ Vision Problems
- ○ Dizziness/Lightheadedness/headaches
- ○ Coordination/balance problems