

**SOUTH CAROLINA SPORTS MEDICINE AND ORTHOPAEDIC CENTER
MEDICAL HISTORY**

Date: ___/___/___ Patient Name: _____ Goes By: _____

Patient Age: _____ Ht _____ Wt _____ Referring Physician: _____

Your reason for today's visit- What specific body part is causing the problem? (Please specify right or left)

Accident Date or Onset of Problem: _____ how did accident or injury occur? _____

Have X-rays been taken for this problem? YES NO When: _____ Where: _____

Do you have your X-rays with you? YES NO

Medical History: Do you or any of your immediate family members have any of the following?

	Yourself		Family member			Yourself		Family member	
	Yes	No	Yes	No		Yes	No	Yes	No
AIDS/HIV					High Blood Pressure				
Alcoholism	Yes	No	Yes	No	Kidney disease	Yes	No	Yes	No
Anemia	Yes	No	Yes	No	Liver Disease	Yes	No	Yes	No
Arthritis	Yes	No	Yes	No	Lung Disease	Yes	No	Yes	No
Bleeding tendencies	Yes	No	Yes	No	Muscular disease	Yes	No	Yes	No
Blood clots (lung / leg)	Yes	No	Yes	No	Prostate disease	Yes	No	Yes	No
Blood transfusion	Yes	No	Yes	No	Seizures	Yes	No	Yes	No
Cancer	Yes	No	Yes	No	Sickle cell disease	Yes	No	Yes	No
Circulation problems	Yes	No	Yes	No	Stroke	Yes	No	Yes	No
Diabetes	Yes	No	Yes	No	Stomach ulcers	Yes	No	Yes	No
Gout	Yes	No	Yes	No	Thyroid disease	Yes	No	Yes	No
Heart attack (MI)	Yes	No	Yes	No	Tuberculosis	Yes	No	Yes	No
Heart disease	Yes	No	Yes	No	Varicose veins	Yes	No	Yes	No
Heart murmur	Yes	No	Yes	No	Urinary tract infections	Yes	No	Yes	No
Hepatitis	Yes	No	Yes	No	Other: _____				

Comments _____

Family History (Please list age of relative below. If not living, list cause of death.) Ex: Father 71 Heart attack

Age (If not living, cause of death.)	Age (If not living, cause of death.)
Mother _____	Brothers/Sisters _____
Father _____	Children _____

Current Medications: (Also include over the counter medicines and birth control pills).

Name	Dose	How often	Name	Dose	How often
Ex: 1. Zantac	150mg	twice a day			
1. _____			4. _____		
2. _____			5. _____		
3. _____			6. _____		

Have you ever taken cortisone pills? YES / NO If yes, when? _____ How long? _____

Have you ever taken cortisone shots? YES / NO If yes, how many? ____ Why? _____

Date of last tetanus shot? ___/___/___

Females: Date of last period ___/___/___ Are you pregnant? YES / NO / POSSIBLY

Are you breastfeeding? YES/NO

CONTINUED ON BACK

Medical History (continued)

Patient Name: _____

Allergies: Ex: 1. Penicillin Hives

Name of drug/food/material	Reaction	Name of drug/food/material	Reaction
1. _____	_____	4. _____	_____
2. _____	_____	5. _____	_____
3. _____	_____	6. _____	_____

Surgical History: Please list in order by year. Ex: Tonsils removed 1964

Name of Procedure	Year	Name of Procedure	Year
1. _____	_____	4. _____	_____
2. _____	_____	5. _____	_____
3. _____	_____	6. _____	_____

Did you have any surgical or anesthetic complications? (If so, please describe. Ex: Blood clot after knee surgery)

Social History: Please answer all questions completely.

Patient's Occupation: _____ Marital status: (circle) married *single* *divorced* *widow*

Do you use cigarettes/cigars/pipes/chew tobacco? YES / NO Packs per day: _____ How long? _____

Alcohol YES / NO Type _____ amount per week _____

Drug use YES / NO Type _____ amount per week _____

Do you participate in sports or other activities? YES / NO If yes, please list: _____

Review of Systems: Do you experience any of the following? Please circle all that apply.

General: *fever* *chills* *recent weight loss or gain*

Eyes: *blurring* *double vision* *wear glasses* *contact lenses*

Ear, Nose, & Throat: *deafness* *sinusitis* *ringing in ears* *hoarseness* *dizziness*

Dental infections *sore throat* *dentures*

Cardiac: *chest pain* *palpitations* *irregular heart beats* *swelling in legs* *fainting spells*

Respiratory: *short of breath* *cough* *wheezing*

Intestinal: *nausea* *vomiting* *decreased appetite* *diarrhea* *constipation*

Abdominal pain *heart burn* *blood in stool*

Urinary: *burning with urination* *urinating frequently* *notice a sudden urgency to urinate*

Difficulty starting stream *incontinence (lack of controlling urine)*

Breast: *lumps*

Musculoskeletal: *stiffness* *muscle or joint pain* *joint swelling*

Skin: *rashes* *sores* *tattoos* *scars* *masses* *ulcers* *itching*

Neurological: *problems w/ speech* *difficulty swallowing* *numbness* *tingling* *weakness*

Visual changes *balance/coordination problems*

Psychiatric: *depression* *nervousness* *eating disorder* *hallucinations* *sleep disturbances*

Endocrine: *excessive thirst* *excessive urination* *heat or cold intolerance*

Hematology/Lymphatic: *bleeding tendency* *swollen glands* *night sweats*