



SPORTS MEDICINE CLINICS: VCU and CHESTER

PATIENT HISTORY

Patient Name: _____ **Age:** _____

Describe the problem you are currently experiencing:

When did you start having this problem? (specify date or month) _____

PAST MEDICAL HISTORY. Are you currently receiving treatment or have you received treatment in the past for any of the following conditions? Please check (✓) yes or no.

- | | | | | | |
|-----|-----|---|-----|-----|------------------------------|
| YES | NO | | YES | NO | |
| ___ | ___ | Anemia (low blood) | ___ | ___ | Hepatitis |
| ___ | ___ | Arthritis | ___ | ___ | High Blood Pressure |
| ___ | ___ | Asthma | ___ | ___ | Intestinal Disorder |
| ___ | ___ | Blood Disorders (clotting problems, sickle cell anemia) | | | |
| ___ | ___ | Cancer | ___ | ___ | Kidney Disease |
| ___ | ___ | Currently Pregnant | ___ | ___ | Recurrent Infections |
| ___ | ___ | Diabetes | ___ | ___ | Rheumatic fever |
| ___ | ___ | Heart Disease | ___ | ___ | Sexually Transmitted Disease |
| ___ | ___ | Stroke | ___ | ___ | Stomach ulcers |

Other MEDICAL HISTORY (Please specify) _____

PAST SURGICAL HISTORY (list surgery type, date performed and name of surgeon)

Surgery: _____ Date (year): _____ Surgeon: _____

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PLEASE CONTINUE WITH SECOND PAGE

MEDICATIONS Are you currently taking any medications. PLEASE LIST BELOW:

Drug Name: _____ Dose/ How many? : _____ How often? _____

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Drug Name: _____ Dose/ How many? : _____ How often? _____

Please ask for additional paper if more space is needed here.

DRUG ALLERGIES. What drugs have you taken in the past cause some type of unusual reaction? Please list the drug and what was the reaction.

Drug Name: _____ What was the reaction? _____

Drug Name: _____ What was the reaction? _____

FAMILY HISTORY Have your mother, father, sister or brother been diagnosed or treated for any of the following conditions? Please check (✓) if present or circle **NO KNOWN FAMILY HISTORY**, if there is no history in your family.

___ Cancer No Known Family history What relative? _____

___ Diabetes No Known Family history What relative? _____

___ Heart Disease No Known Family history What relative? _____

___ Tuberculosis No Known Family history What relative? _____

___ Arthritis No Known Family history What relative? _____

REVIEW OF SYSTEMS Please check (✓) if you have experienced these symptoms in the past 6 months.

GENERAL ___ fever ___ night sweats ___ weight gain ___ weight loss
EYES ___ blurring ___ eye strain ___ glasses/contact lenses
THROAT ___ hoarseness ___ difficulty swallowing
NOSE ___ sinus drainage ___ obstruction
HEAD ___ headaches ___ fainting ___ blackouts ___ seizures
EARS ___ deafness ___ ringing in the ears ___ pain ___ discharge
STOMACH ___ vomiting ___ belching ___ diarrhea ___ nausea ___ constipation
SKIN ___ rash ___ cyanosis (blue skin) ___ jaundice (yellow skin)
URINARY ___ pain ___ frequent urination ___ incontinence
NEURO ___ weakness ___ joint pain ___ tingling/numbness ___ loss of sensation
CARDIAC ___ chest pain ___ rapid heartbeat ___ fainting ___ leg swelling
LUNGS ___ wheezing ___ difficulty breathing ___ blood in sputum

Patient Signature: _____ Date: _____

Clinic Staff Review: _____ MD Initials/ Nurse Signature Date: _____