SPORTS MEDICINE PATIENT HISTORY

Patient Name: ______________________ **Date of birth:** ______________________

Person completing form: ______________________ **Relation:** ______________________

REASON FOR VISIT: ______________________

SOCIAL HISTORY: Grade in school: ________ School: ______________________ # of Siblings________

With whom does patient live?______________________ Parents' Occupation ______________________

BIRTH HISTORY: Birth weight:______ lb ______ oz Gestation Age: How many weeks? ________ Full term ☐ Premature ☐

Delivery: Vaginal ☐ C-section ☐ Breech? Yes / No Complications? Yes / No If Yes:______________________

IMMUNIZATIONS: Is patient up to date? No ☐ Yes ☐

SURGERIES: No ☐ Yes ☐ If yes, list the type and date ______________________

HOSPITALIZATIONS: No ☐ Yes ☐ If yes, list the type and date______________________

MEDICATIONS/SUPPLEMENTS: No ☐ Yes ☐ If yes, list the name and dose ______________________

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Medication Allergies: No ☐ Yes ☐ If yes, list the name& reaction ______________________

Family History: Scoliosis No ☐ Yes ☐ Ankylosing Spondylitis No ☐ Yes ☐
Hip Dysplasia No ☐ Yes ☐ Inflammatory Arthritis No ☐ Yes ☐

REVIEW OF SYSTEMS: Does your child have any of the following now or in the past?

	No	Yes
Constitutional		
Unusual weight loss	☐	☐
Repeated unexplained fevers	☐	☐
Allergies		
Seasonal allergies	☐	☐
Food allergies	☐	☐
Blood/Circulation		
Anemia	☐	☐
Bleeding tendencies	☐	☐
Sickle cell trait/disease	☐	☐
Cardiovascular		
Heart Problems	☐	☐
Dermatology		
Skin rashes	☐	☐
Endocrine		
Thyroid problems	☐	☐
Diabetes	☐	☐
Growth problems	☐	☐
Menstrual periods	☐	☐
LMP _________ 1st MP__________		
Ears, Nose & Throat		
Recurrent ear/sinus infections	☐	☐
Snoring	☐	☐

	No	Yes
Eye		
Vision problems	☐	☐
GI		
Jaundice	☐	☐
Constipation	☐	☐
Diarrhea	☐	☐
Vomiting	☐	☐
Stomach pain	☐	☐
Kidney/urinary problems		
Urine infections	☐	☐
Musculoskeletal		
Joint problems	☐	☐
Scoliosis	☐	☐
Broken bones	☐	☐
Respiratory		
Pneumonia	☐	☐
Asthma/Reactive airway	☐	☐
Persistent cough	☐	☐
Neuro/Developmental		
Headaches	☐	☐
Seizures	☐	☐
Learning disorders	☐	☐
ADHD	☐	☐
Genetic problems	☐	☐

If yes to any please explain:

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Other ______________________

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Signature:

____

Date:

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