ORTHOPEDIC CENTER FOR SPORTS MEDICINE
PRESENT MEDICAL HISTORY QUESTIONNAIRE

DATE: _____

NAME: _____ AGE: _____

DIRECTIONS: Please answer the following questions to the best of your ability. If you need additional space, Use **the back of the paper. If you have any questions, check with the receptionist.**

1. What is the problem? Please describe: _____
   _____
   _____
   _____

2. How long has the problem been present? _____ Date of onset? _____

3. Is the problem the result of an injury? _____ If yes, please describe the injury:_____
   _____

4. Were you seen in an Emergency Room for this problem? _____ When? _____Where?_____
   Please describe the diagnosis and treatment: _____
   _____

5. Were you ever hospitalized for this problem? _____ When? _____ Where? _____Who was your doctor? _____ Please describe the diagnosis and treatment: _____
   _____

6. Did you have previous surgery for this problem? _____When? _____ Where? _____Who was your doctor? _____ Please describe the diagnosis and treatment: _____
   _____

7. Have you been seen at a doctor's office, physical therapy, or other health care provider? _____
   When?_____ Where? _____ Please describe the diagnosis and treatment: _____
   _____

8. Is your problem getting worse, better, or staying the same? _____

9. What makes it worse? _____

10. What makes it better? _____

11. Please list <u>all</u> of your current medication(s) and dosage (including prescription and non-prescription).
    _____
    _____
    _____

12. What type of work do you perform? _____

13. Did this problem occur at work? _____ Work Related? _____ Please describe: _____
    _____

14. Is your problem related to sports or exercise? _____ If yes, please describe your average activity per week: _____

15. What other factors are important in describing your problem? _____
    _____

16. Who recommended that you come here for your evaluation? Doctor? Friend? Coach? Lawyer? Family Member? Please give name and affiliation: _____

17. Are you allergic to any medications? _____If yes, please list medications and describe problem or reaction to each: _____
    _____

ORTHOPEDIC CENTER FOR SPORTS MEDICINE
PAST MEDICAL HISTORY QUESTIONNAIRE

NAME: _____ DATE: _____
AGE: _____

DIRECTIONS: **Please answer the following questions to the best of your ability. If you need additional space, use the back of the paper. If you have any questions, please check with the receptionist.**

1. Did you ever have any serious childhood illnesses or injuries? _____If yes, please describe condition and age: _____
   _____
2. Did you ever have any serious adolescent illnesses or injuries? _____ If yes, please describe condition and age: _____
3. Did you ever have any serious adult illnesses or injuries? _____ If yes, please describe condition and age: _____
4. What is your current health? Excellent - Fair - Poor?
5. What major or minor conditions have you been diagnosed as having? Please list and describe: _____
   _____
   _____
6. List all of your previous surgeries and approximate dates: _____
   _____
   _____
7. How much do you smoke? _____
8. How much alcohol do you drink? _____ What type?_____

Biographical Data

9. Where have you spent most of your life? "HOMETOWN"? _____
10. Where do you presently live? _____
11. Occupation? _____
12. Marital Status? _____
13. How many children do you have? _____Give their names and ages:_____
    _____
14. Recreational Activities? _____

Family Medical History

List the conditions diagnosed in your family members and their present health and age.

15. Your father: _____
16. Your mother: _____
17. Your spouse: _____
18. Your children: _____
    _____