South Carolina Sports Medicine & Orthopaedic Center

Patient Health History

Patient Name: ____ **Goes by:** ____________________ **Date:** ___ /____/___

Age_______ **Height**_______ ft ________ in **Weight**______ lbs **Referring Dr.**________________________________

Reason for today's visit – What specific body part is causing the problem (Please Specify Left or Right)

____

Accident Date/Onset of Problem________________ **How did the injury occur?** ______________________________

Have x-rays been taken for this problem? YES / NO **When**: ______________ **Where**: ______________________

Do you have your x-rays with you? YES / NO **Did you go to ER:** Yes or No **If Yes Where**:______________________

Allergies: (Example: Penicillin - Hives)

Name of Drug / Food/ Material Reaction | Name of Drug/Food/Material Reaction

1.____
2.____
3.____
4.____
5.____
6.____

Current Medications:

1.____
2.____
3.____
4.____
5.____
6.____
7.____
8.____

Did you have any surgical or anesthetic complications? ____

Do you have a pacemaker? Yes / No **Do you have any recent tattoos?** Yes / No

Do you have a stent or any implants /metal fragments in your body? Yes / No ___________________________________

Date of last: tetanus shot_______ **Flu shot**________ **Pneumonia shot** ________ **Covid Vaccines** ______ _______

Are you: Pregnant: Y or N **Breast Feeding** Y or N **Date of Last Period** ________________

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

	YOURSELF	FAMILY	WHO
International Travel	Y or N	Y or N	__________
AIDS/HIV	Y or N	Y or N	__________
Alcoholism	Y or N	Y or N	__________
Anemia	Y or N	Y or N	__________
Anesthesia Probs	Y or N	Y or N	__________
Anxiety	Y or N	Y or N	__________
Arthritis	Y or N	Y or N	__________
Asthma	Y or N	Y or N	__________
Bleeding Tend.	Y or N	Y or N	__________
Blood Clot (lung/leg)	Y or N	Y or N	__________
Blood Transfusion	Y or N	Y or N	__________
Bone Disease	Y or N	Y or N	__________
Cancer	Y or N	Y or N	__________
Cholesterol Probs.	Y or N	Y or N	__________
Circulation Probs.	Y or N	Y or N	__________
Depression	Y or N	Y or N	__________
Diabetes	Y or N	Y or N	__________
Fever	Y or N	Y or N	__________
Fibromyalgia	Y or N	Y or N	__________
GERD	Y or N	Y or N	__________
Gout	Y or N	Y or N	__________
Heart Attack (MI)	Y or N	Y or N	__________
Heart Disease	Y or N	Y or N	__________
Heart Murmur	Y or N	Y or N	__________
Hepatitis	Y or N	Y or N	__________
High Blood Pressure	Y or N	Y or N	__________
Kidney Disease	Y or N	Y or N	__________
Liver Disease	Y or N	Y or N	__________
Lung Disease	Y or N	Y or N	__________
Mood Disorder	Y or N	Y or N	__________
Muscular Disease	Y or N	Y or N	__________
Prostate Disease	Y or N	Y or N	__________
Seizures	Y or N	Y or N	__________
Sickle Cell Disease	Y or N	Y or N	__________
Sleep Apnea	Y or N	Y or N	__________
Stomach Ulcers	Y or N	Y or N	__________
Stroke	Y or N	Y or N	__________
Thyroid Disease	Y or N	Y or N	__________
Tuberculosis	Y or N	Y or N	__________
Varicose Veins	Y or N	Y or N	__________
Urinary Tract Infect.	Y or N	Y or N	__________

Other: ____________________________________

Health History (continued)

Family History: List ages of relatives below. If not living, list cause and age of death.

Mother's age________________________________ Brother(s) / Sister(s) age ______________________________

Father's age________________________________ Children____

Social History: Please answer all questions completely.

Occupation: ____________________________________ Employer_______________________________________

Marital Status: _____________________ School: _______________________________ Grade: _______________

Tobacco Use: Y or N or Former Smoker Type _______________ Packs per Day __________ How long _________

Alcohol: Y or N Type____________________________ Amount per week ________________________________

Drug Use: Y or N Type____________________________ Amount per week _______________________________

Dominant Hand: Right or Left or Both **Are you under a pain contract?** Y/N Where: _______________________

Do you have: Advanced Directive- Y or N **Health Care Power of Attorney-** Y or N **DNR Order-** Y or N

Do you participate in Sports or other activities? Y or N / If yes please list: __________________________________

Surgical History: Please list in order by year. Ex: Tonsillectomy – May 6, 1964

Name of Procedure	Year	Name of Procedure	Year
1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	

Did you have any surgical or anesthetic complications? ____

Review of Systems: Have you experienced any of the following within the last 30 days? Circle all that apply.

Constitutional: Fever | Chills | Night Sweats | Recent Weight Gain | Recent Weight Loss | Exercise Intolerance

Ears: Ringing in Ears | Difficulty Hearing/Deafness | Ear Pain

Eyes: Dry Eyes | Irritation | Wear Glasses | Wear Contacts

Nose: Frequent Nosebleeds, | Nose/Sinus Problems

Mouth/Throat: Sore Throat | Bleeding Gums | Snoring | Dry Mouth | Oral Abnormalities | Mouth Ulcer | Teeth Abnormalities/Dentures | Mouth Breathing | Hoarseness | Dental Infections

Cardiovascular: Chest Pain w/ Exertion | Arm Pain w/ Exertion | Shortness of Breath When Walking | Palpitations | Shortness of Breath When Lying Down | Swelling in Legs | Known Heart Murmur | Irregular Heart Beat | Fainting

Respiratory: Cough | Wheezing | Shortness of Breath | Coughing Up Blood | Sleep Apnea

Gastrointestinal: Abdominal Pain | Vomiting | Change in Appetite | Black or Tarry Stools | Frequent Diarrhea | Vomiting Blood | Nausea | Heartburn

Genitourinary: Urinary Loss of Control | Difficulty Urinating | Increased Urinary Frequency | Hematuria | Incomplete Emptying | Burning with Urination | Difficulty Starting Stream

Musculoskeletal: Muscle Aches/Stiff | Muscle Weakness | Arthralgia/Joint Pain | Back Pain | Swelling in Extremities

Integumentary: Abnormal Mole | Jaundice | Rash | Itching | Dry Skin | Growths/Lesions | Tattoos | Masses

Neurologic: Loss of Consciousness | Weakness | Numbness | Tingling | Seizures | Dizziness | Migraines | Restless Legs | Frequent/Severe Headaches | Problems w/ Speech | Visual Change | Balance Problems

Psychiatric: Depression | Sleep Disturbances | Restless Sleep | Feeling Unsafe in Relationship | Alcohol Abuse, | Eating Disorder | Anxiety | Hallucinations

Endocrine: Fatigue | Increased Thirst | Hair Loss | Increased Hair Growth | Cold Intolerance | Heat Intolerance

Hematology/Lymphatic: Bleeding Tendency | Swollen Glands | Night Sweats