

# VIRGINIA INSTITUTE FOR SPORTS MEDICINE

## NEW PATIENT MEDICAL HISTORY

Date \_\_\_\_\_

Chart # \_\_\_\_\_

PCP \_\_\_\_\_

Patient's Name \_\_\_\_\_ Ref Physician \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_ Date of last tetanus \_\_\_\_\_

Problems with anesthesia?  YES  NO If yes, explain \_\_\_\_\_

Current Complaints \_\_\_\_\_

Allergies/Difficulty with Medication _ None	Reaction	Current Medication _ None	How Taken
1. _____	_____	1. _____	_____
2. _____	_____	2. _____	_____
3. _____	_____	3. _____	_____
4. _____	_____	4. _____	_____
5. _____	_____	5. _____	_____

### PERSONAL MEDICAL HISTORY

- |  |  |   |   |
|--|--|---|---|
| <input type="checkbox"/> No Illness          | <input type="checkbox"/> Pneumonia                     | <input type="checkbox"/> Bladder/Kidney Infection   | <input type="checkbox"/> Scarlet Fever                |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Tuberculosis                  | <input type="checkbox"/> Arthritis                  | <input type="checkbox"/> Bleeding Disorders           |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Heart Attack or Heart Disease | <input type="checkbox"/> Cancer                     | <input type="checkbox"/> Intestinal Problems          |
| <input type="checkbox"/> Stroke              | <input type="checkbox"/> Ulcers                        | <input type="checkbox"/> Mental or Nervous Disorder | <input type="checkbox"/> Angina                       |
| <input type="checkbox"/> Emphysema           | <input type="checkbox"/> Hepatitis                     | <input type="checkbox"/> Seizures                   | <input type="checkbox"/> Heart Murmurs/Valve Problems |
| <input type="checkbox"/> Bronchitis          | <input type="checkbox"/> Gallbladder Disease           | <input type="checkbox"/> Venereal Disease           | <input type="checkbox"/> Other                        |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Pancreatitis                  | <input type="checkbox"/> AIDS/HIV                   |   |

Specify \_\_\_\_\_

### SOCIAL HISTORY

Do you smoke cigarettes?  YES  NO How many packs per day? \_\_\_\_\_

Do you drink alcohol?  YES  NO Number of drinks per day? \_\_\_\_\_ per week \_\_\_\_\_

Do you take drugs?  YES  NO Check all that apply:  Marijuana  Cocaine  Others  
(specify) \_\_\_\_\_

Marital Status:  Married  Single  Divorced  Separated  Number of Children \_\_\_\_\_

Are You:  Right Handed  Left Handed

Employment (Type): \_\_\_\_\_

### FAMILY HISTORY (Siblings, parents and children)

	Date	Initial
<input type="checkbox"/> No Disease	_____	_____
<input type="checkbox"/> Tuberculosis	_____	_____
<input type="checkbox"/> Diabetes	_____	_____
<input type="checkbox"/> Kidney Disease	_____	_____
<input type="checkbox"/> High Blood Pressure	_____	_____
<input type="checkbox"/> Arthritis	_____	_____
<input type="checkbox"/> Heart Disease	_____	_____
<input type="checkbox"/> Asthma	_____	_____
<input type="checkbox"/> Stroke	_____	_____
<input type="checkbox"/> Seizures	_____	_____
<input type="checkbox"/> Cancer	_____	_____
<input type="checkbox"/> Excessive Bleeding	_____	_____
<input type="checkbox"/> Problems with Anesthesia	_____	_____
<input type="checkbox"/> Other (specify) _____	_____	_____

Physician Signature \_\_\_\_\_