

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 _____