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._____		4._____	
2._____		5._____	
3._____		6._____	

Current Medications:

1._____ 5._____
2._____ 6._____
3._____ 7._____
4._____ 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		YOURSELF	FAMILY	WHO
International Travel	Y or N	Y or N	_____	Heart Attack (MI)	Y or N	Y or N	_____
AIDS/HIV	Y or N	Y or N	_____	Heart Disease	Y or N	Y or N	_____
Alcoholism	Y or N	Y or N	_____	Heart Murmur	Y or N	Y or N	_____
Anemia	Y or N	Y or N	_____	Hepatitis	Y or N	Y or N	_____
Anesthesia Probs	Y or N	Y or N	_____	High Blood Pressure	Y or N	Y or N	_____
Anxiety	Y or N	Y or N	_____	Kidney Disease	Y or N	Y or N	_____
Arthritis	Y or N	Y or N	_____	Liver Disease	Y or N	Y or N	_____
Asthma	Y or N	Y or N	_____	Lung Disease	Y or N	Y or N	_____
Bleeding Tend.	Y or N	Y or N	_____	Mood Disorder	Y or N	Y or N	_____
Blood Clot (lung/leg)	Y or N	Y or N	_____	Muscular Disease	Y or N	Y or N	_____
Blood Transfusion	Y or N	Y or N	_____	Prostate Disease	Y or N	Y or N	_____
Bone Disease	Y or N	Y or N	_____	Seizures	Y or N	Y or N	_____
Cancer	Y or N	Y or N	_____	Sickle Cell Disease	Y or N	Y or N	_____
Cholesterol Probs.	Y or N	Y or N	_____	Sleep Apnea	Y or N	Y or N	_____
Circulation Probs.	Y or N	Y or N	_____	Stomach Ulcers	Y or N	Y or N	_____
Depression	Y or N	Y or N	_____	Stroke	Y or N	Y or N	_____
Diabetes	Y or N	Y or N	_____	Thyroid Disease	Y or N	Y or N	_____
Fever	Y or N	Y or N	_____	Tuberculosis	Y or N	Y or N	_____
Fibromyalgia	Y or N	Y or N	_____	Varicose Veins	Y or N	Y or N	_____
GERD	Y or N	Y or N	_____	Urinary Tract Infect.	Y or N	Y or N	_____
Gout	Y or N	Y or N	_____	Other:	_____		

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