

Kettering Sports Medicine Center- Medical History

Name: _____ Age: _____ Surgery Date: _____ Email: _____

Occupation: _____ Leisure Activities/Sport: _____ School: _____

Specific Job Duties: _____ Are you currently working? _____

Diagnosis/Problem: _____

What Happened and When? _____

ALLERGIES: List any medication(s) you are allergic to: _____

Are you latex sensitive? YES NO Are you allergic to bee stings? YES NO

List any other allergies/sensitivities: _____

List **ALL** medications or supplements you are currently taking: _____

Have you ever been diagnosed with any of the following conditions? If yes, please give the date diagnosed.

Allergies	YES	NO	Dizziness/Faintness	YES	NO	Myocardial Infarction	YES	NO
Anemia	YES	NO	Diabetes Mellitus	YES	NO	Nerve/Muscle Disease	YES	NO
Anxiety	YES	NO	Emphysema	YES	NO	Osteoporosis	YES	NO
Arthritis	YES	NO	GERD / Reflux	YES	NO	Seizures	YES	NO
Asthma	YES	NO	Glaucoma	YES	NO	Sickle Cell Anemia	YES	NO
Blood Transfusion	YES	NO	Heart Murmur	YES	NO	Stroke	YES	NO
Cancer	YES	NO	Hepatitis	YES	NO	Chemical Dependency	YES	NO
Cataracts	YES	NO	HIV/AIDS	YES	NO	Thyroid Disease	YES	NO
CHF/Congestive Heart Failure	YES	NO	Hypertension	YES	NO	Tuberculosis	YES	NO
Clotting Disorder	YES	NO	Kidney Disease	YES	NO	Ulcers	YES	NO
COPD	YES	NO	Meningitis	YES	NO	OTHER _____		
Depression	YES	NO	MRSA	YES	NO			

Have you been hospitalized or in a skilled nursing facility in the last 30 days? YES NO

Have you had a test for bone density? YES NO If yes, date: _____

Please list **ALL** previous surgeries (with date) performed: _____

Do you smoke? YES NO (packs per day _____) Is it possible you are pregnant? YES NO

Do you consume alcoholic beverages? YES NO (amount per day _____)

Have you recently had any additional stress in your life? If so, please explain: _____

Do you feel **unsafe** in a current relationship? _____ Have you been a victim of a violent crime? _____

Which hand do you write with? _____

Are there cultural/religious practices that may affect your healthcare? _____ If so, please explain: _____

What do you hope to achieve from therapy? _____

Are your symptoms (please circle): IMPROVING WORSENING NO CHANGE CONSTANT INTERMITTENT

Where are your symptoms? _____

Rate your pain on a scale of 0 to 10, with 0 being no pain and 10 being go to the Emergency Room:

Pain at its least: 0 1 2 3 4 5 6 7 8 9 10

Pain at its worst: 0 1 2 3 4 5 6 7 8 9 10

How would you describe your pain? (please circle) Sharp Ache Burn Cramp Throb Shooting Other _____

What makes the pain worse? _____

What makes the pain better? _____

Have you been treated for this problem in the past year? YES NO If yes, what? _____

Have you had any tests for this problem? (Please circle and note date): X-Ray MRI EMG CT Scan Other _____

Have you been given precautions/restrictions? If yes, describe _____

Do you currently have:

Melaise (feeling that something is not right)	YES	NO	Change in mental abilities	YES	NO	Nausea/Vomiting	YES	NO
Dizziness/Light headedness	YES	NO	Fatigue	YES	NO	Weakness	YES	NO
Tingling/Numbness	YES	NO	Fever/Chills	YES	NO	Night Pain	YES	NO
Bowel and Bladder Changes	YES	NO	Unexplained weight gain/loss (at least 5lbs) in the last 6 weeks	YES	NO			

Would you say your health is (please circle): EXCELLENT GOOD FAIR POOR

Have you fallen in the past year? _____ If yes, how many times? _____ Was the injury significant? _____

Do you live in a: (please circle) House Mobile Home Apartment Condominium Other _____

Do you live alone? _____ Do you have stairs at/in your home? _____ If yes, how many? _____

Check any activities you have difficulty with:

Getting in/out of bed	_____	Sleeping	_____	Reaching high shelves	_____
Bathing/ Self Care	_____	Dressing	_____	Rising from a chair	_____
Meal Preparation	_____	Lifting	_____	Prolonged sitting (45 min +)	_____
Job Functions	_____	Stairs	_____	Walking longer than 20 min.	_____
Getting in/out of vehicle	_____	Driving	_____	Leisure activities/sports	_____
Bending/kneeling	_____	Vacuuming	_____	Household chores/sweeping	_____

To the best of my ability, I have given and included all pertinent medical information.

Patient/Guardian Signature

Date

Reviewed by P.T. and used in determining the Plan of Care

Date