



Kettering Sports Medicine Center Physician's Medical History

Name: _____ DOB: _____ Today's Date: _____

Email: _____ **School / Team:** _____ Gender: Male Female

Occupation/**Grade:** _____ Activities / Sports: _____

Specific Job Duties / Team Position: _____ Are you currently attending school? _____

Are you currently working? _____ How did you hear about our facility? _____

Allergies and Medications:

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

Are you latex sensitive? YES NO

List any other allergies / sensitivities: _____

List ALL medications and dosages or supplements you are currently taking: _____

Medical History: Check if you (or a family member) have had any of the following conditions in the past

Condition	Self Yes	Ex. Parents , siblings, maternal/paternal grandparents		Condition	Self Yes	Ex. Parents , siblings, maternal/paternal grandparents	
		Yes	Family Member Who?			Yes	Family Member Who?
ADD / ADHD	___	___	_____	MRSA	___	___	_____
Anemia	___	___	_____	Myocardial Infarction	___	___	_____
Arthritis	___	___	_____	Obesity	___	___	_____
Asthma	___	___	_____	Osteoporosis	___	___	_____
Cancer	___	___	_____	Pneumonia	___	___	_____
Clotting Disorder	___	___	_____	Scoliosis	___	___	_____
Diabetes Mellitus	___	___	_____	Seizures	___	___	_____
Heart Murmur	___	___	_____	Sickle Cell Anemia	___	___	_____
Hypertension	___	___	_____	Stroke	___	___	_____
Inflammatory Bowl	___	___	_____	Other: _____	___	___	_____
Meningitis	___	___	_____	Other: _____	___	___	_____

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

Which hand do you write with? _____ Is it possible you are pregnant? YES NO N/A

Do you smoke cigarettes or cigars? YES NO (packs per day _____) Have you ever smoked? YES NO

Do you use smokeless tobacco? YES NO (amount per day _____)

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

Do you use any other street drugs (i.e. marijuana, meth, cocaine, IV)? If so, please explain: _____

Current Medical Status: _____ *Comment about current injury*

Body Part Injured / Being Evaluated today? Right Left _____

Problem / Issues: _____

What Happened and When? _____

Have you had treatment for this problem at another medical establishment or practitioner in the past year? YES NO

If so, please explain: _____

Please shade area of pain

Describe your pain: (Please Circle) Sharp Aching Burning Throbbing

Dull Shooting Cramping Other: _____

What makes pain worse? _____

What makes pain better? _____

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

Is there swelling? _____ Is there weakness? _____

Is there any limited motion? _____

Rate your pain on a scale of 0 to 10, with 0 being no pain and 10 being worst pain imaginable:

Pain level currently: 0 1 2 3 4 5 6 7 8 9 10

Previous tests for this problem? (Please circle and note date): X-Ray MRI EMG CT Scan Bone Scan Other _____

What were the results of the test? _____

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

Have you been given exercises for this problem? _____

Previous musculoskeletal injuries and approximate date: _____

Do you currently have?

- | | | |
|--|--------------------------|---------------------------------|
| ___ Fever | ___ Cough | ___ Rash |
| ___ Chills | ___ Leg swelling | ___ Headache |
| ___ Congestion | ___ Nausea | ___ Sensitivity to Noise |
| ___ Runny nose | ___ Vomiting | ___ Mood change or irritability |
| ___ Blurry vision (sensitivity to light) | ___ Difficulty urinating | ___ Sleep disturbance |

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

Patient/Guardian Signature _____ **Date:** _____