Name:
DOB:
Chart:
Age:
Date:

Carolina Sports Medicine & Orthopaedic Specialists

Medical History

Patient's Name: _____ Today's Date _____ Age _____ Birth Date _____

PRIMARY CARE PHYSICIAN: _____ Height: _____ Weight: _____

Please circle "Y" below if you have problems with these medical conditions and "N" if you do not have problems:

Skin/Breast:
- Y N Rash or problems with itching
- Y N Varicose veins
- Y N Breast lump

Eyes/Ears/Nose/Mouth/Throat:
- Y N Blurred or double vision
- Y N Eyes diseases
- Y N Hearing loss or ringing
- Y N Earaches or ear drainage
- Y N Sinus problems or "runny nose"
- Y N Nose bleeds
- Y N Loose or chipped teeth
- Y N Dentures or bridge
- Y N Problems opening mouth wide
- Y N Sore throat or change in your voice
- Y N Swollen glands in your neck
- Y N Blind
- Y N Deaf

Lungs:
- Y N Breathing problems or asthma
- Y N Breathing problems during sleep
- Y N Tuberculosis or emphysema

Cardiac (Heart and Blood Vessels):
- Y N Chest pain or angina pectoris
- Y N Heart disease or heart trouble
- Y N Recent chest pressure or tightness
- Y N Shortness of breath on exertion
- Y N Shortness of breath when lying flat
- Y N High blood pressure
- Y N Recent heart palpitations
- Y N Swelling of the feet, ankles, or hands
- Y N Bleeding disorder
- Y N Take a blood thinner, e.g., Coumadin
- Y N Blood clots
- Y N Stents
- Y N Defibrilator/Pacemaker

Endocrine:
- Y N Diabetes or high blood sugar
- Y N Do you take insulin?

Intestines and Kidneys:
- Y N Frequent, burning or painful urination
- Y N Blood in your urine
- Y N Urinary incontinence or dribbling
- Y N Kidney stones
- Y N Kidney or liver disease
- Y N Change in bowel movements
- Y N Nausea or vomiting
- Y N Frequent diarrhea
- Y N Rectal bleeding or blood in your bowel movements
- Y N Frequent abdominal pain or heartburn

Males: Testicle pain Y N

Males: Prostate problems Y N

Females: Number of pregnancies _____

Pregnant Y N

Musculoskeletal:
- Y N Arthritis
- Y N Osteoporosis
- Y N Major Fractures

Neurological (Nerves):
- Y N Frequent, recurring headaches
- Y N Dizziness
- Y N Numbness or tingling sensations
- Y N Convulsions, seizures or tremors
- Y N Any kind of head injury
- Y N Stroke or "mini stroke"
- Y N Spinal Stimulator

Psychiatric:
- Y N Memory loss or confusion
- Y N Feelings of nervousness
- Y N Feelings of depression
- Y N Trouble sleeping

Social:
- Y N Drink alcoholic beverages
  If yes, how much? _____
- Y N Use any recreational drugs
- Y N Smoke (circle): Daily Occasional Never Former Unknown
  Year Started _____
  Year Stopped _____

Infectious Diseases:
- Y N HIV+
- Y N Hepatitis +
- Y N MRSA
- Y N Lyme Disease

Anesthesia History:
- Y N Any anesthesia problems other than nausea or vomiting?
- Y N Difficulty opening your mouth?
- Y N Family history of malignant hypertension?
- Y N History of prolonged weakness after anesthesia?

Family History:
(Circle "Y" for all that apply)
- Y N Diabetes
- Y N Bleeding Tendency
- Y N Cancer
- Y N Sickle Cell
- Y N Hypertension
- Y N Heart Disease
- Y N Blood Clots
- Y N Stroke
- Y N Heart Attack

Review of Health History:

	Yes	No	Unknown
Have you been in good general health lately?	☐	☐	☐
Have you experienced a recent unplanned weight loss?	☐	☐	☐
Have you been running a fever?	☐	☐	☐
Have you been feeling fatigued?	☐	☐	☐

Name:
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Patient Name: _____

Recent Procedures/Tests	When?	Where?	Medications	Dose	How often?

Past Surgeries	What Facility?	Problems?	Medications	Dose	How often?
		Y N			
		Y N			
		Y N			
		Y N			
		Y N			
		Y N			
		Y N			

USUAL PHARMACY: _____

List any other information regarding medical problems:

Allergies:

Family History of Illnesses:

Father: _____

Mother: _____

Brothers/Sisters: _____

I certify that this information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature _____ Date _____