PLEASE PRINT

Date _____

Patient Name _____
Last First MI

Date of Birth _____ Age _____ Height _____ Weight _____

Antihistmine or Drug Allergies _____

What prescription/non prescription medicine / supplements do you take? (Additional space on back of form)

_____

PAST MEDICAL HISTORY Have you ever had the following? (Check yes or no. Leave blank if uncertain)

AIDS or HIV +	❑ Yes	❑ No
Anemia	❑ Yes	❑ No
Arthritis	❑ Yes	❑ No
Asthma	❑ Yes	❑ No
Back Trouble	❑ Yes	❑ No
Bladder Infections	❑ Yes	❑ No
Bleeding Tendency	❑ Yes	❑ No
Bronchitis	❑ Yes	❑ No
Cancer	❑ Yes	❑ No
Chickenpox	❑ Yes	❑ No
Diabetes	❑ Yes	❑ No
Diphtheria	❑ Yes	❑ No
Glaucoma	❑ Yes	❑ No
Heart Disease	❑ Yes	❑ No
Hemorrhoids	❑ Yes	❑ No
Hepatitis	❑ Yes	❑ No
Hernia	❑ Yes	❑ No
High or Low BP	❑ Yes	❑ No
Hives or Eczema	❑ Yes	❑ No
Infectious Mono	❑ Yes	❑ No
Kidney Disease	❑ Yes	❑ No
Measles	❑ Yes	❑ No
Migraines	❑ Yes	❑ No
Mitral Valve	❑ Yes	❑ No
Pneumonia	❑ Yes	❑ No
Mumps	❑ Yes	❑ No
Polio	❑ Yes	❑ No
Rheumatic Fever	❑ Yes	❑ No
Scarlet Fever	❑ Yes	❑ No
Smallpox	❑ Yes	❑ No
Stroke	❑ Yes	❑ No
Transfusions	❑ Yes	❑ No
Tuberculosis	❑ Yes	❑ No
Ulcer	❑ Yes	❑ No
Venereal Disease	❑ Yes	❑ No
Whooping Cough	❑ Yes	❑ No

Any other disease – Please list

_____

_____

THE LAST TIME YOU HAD (list year)

Cholesterol Test	_____	Rectal Exam	_____
Eye Exam	_____	Rubella Vaccine	_____
Flu Vaccine	_____	Sigmoidoscopy	_____
Hepatitis Vaccine	_____	Stool Blood Test	_____
Pneumonia Shot	_____	TB Test	_____
PSA Test	_____	Tetanus Shot	_____

SOCIAL HISTORY

Alcohol	❑ Yes	❑ No	drinks/week _____
Caffeine	❑ Yes	❑ No	cups/day _____
Illegal Drugs	❑ Yes	❑ No	type _____
Tobacco	❑ Yes	❑ No	pack/day _____ years _____

Relative	Age	Deceased	Health Problems
Father			
Mother			
Siblings			
Grandparents			

Year	Illness / Operation

FOR FEMALES ONLY

Age onset menstrual period _____ Date last menstrual period _____

Duration of periods _____ Date of last PAP Test _____

Had painful menstruation? ❑ Yes ❑ No Had irregular menstruation? ❑ Yes ❑ No

Use birth control? ❑ Yes ❑ No Type _____

YEAR OF LAST Breast Exam _____ Was it normal? ❑ Yes ❑ No

Number of pregnancies _____ Number of abortions _____

Number of live births _____ Number of miscarriages _____

FOR MALES ONLY

Any Swelling of testicles? ❑ Yes ❑ No Any problems obtaining or maintaining an erection? ❑ Yes ❑ No

PATIENT IDENTIFICATION LABEL

MAX SPORTS MEDICINE

PATIENT HEALTH QUESTIONNAIRE

3006664 (9/3/2009)

Patient Name _____ Date _____

MEDICATIONS & SUPPLEMENTS	DOSE & FREQUENCY