CAPE FEAR SPORTS MEDICINE

Medical History

Name:_____ Age:_____ Birth Date:_____

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

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 Eye 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 voice
Y N Swollen glands in your neck

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

Cardiac (Heart or 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 feet, ankles, or hands
Y N Bleeding disorder
Y N Take a blood thinner, eg.Coumadin

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

Intestines and Kidneys:
Y N Frequent/ burning /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 Freq. abdominal pain / heartburn
Y N Males: Testicle pain
Y N Males: Prostate problems
Females: Number of Pregnancies:___

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"

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
If yes, how much?

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

Past Surgeries / Where? / Problems?
_____ **Y N**
_____ **Y N**
_____ **Y N**

Recent Procedures/Tests When? Where?
_____
_____
_____
_____

Other Medical Problems:
_____
_____
_____
_____
_____
_____

Medications Dose How often?
☐ **NONE**
_____
_____
_____
_____
_____
_____
_____
_____
_____

Drug Allergies: ☐ NONE KNOWN
_____
_____
_____
_____
_____

Are you allergic to latex gloves?
_____Yes _____No

Height:_____ Weight:_____

Primary Care Physician:_____

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.

_____
Patient Signature Date

Provider Reviewed:

_____
Provider Signature Date

_____
Provider Signature Date

_____
Provider Signature Date

_____
Provider Signature Date