Pinsky Family and Sports Medicine Center
Patient History & Physical Information Sheet

Please complete the following information

Name: _____

Past Medical History (Check all that apply)

☐ Measles	☐ Rheumatic Fever	☐ Scarlet Fever
☐ Mumps	☐ TB (or exposure)	☐ Polio
☐Chicken Pox	☐ German Measles	

☐ Arthritis	☐ Gall Bladder Disease	☐Seizures
☐ Cancer	☐ Heart Disease	☐ Stroke
☐ Depression/Anxiety	☐ Kidney Disease	☐ Thyroid Disease
☐ Diabetes	☐ Liver Disease	☐ Ulcer Disease
☐ Elevated Cholesterol	☐ Lung Disease	☐ Hypertension

Please list any major injuries

_____
_____
_____
_____

Please list past medical surgical history

_____
_____
_____
_____

Please list <u>all</u> medications you are presently taking on a regular basis (including any over-the-counter medications, vitamins, minerals, and herbal supplements):

_____ _____
_____ _____
_____ _____
_____ _____

Please list <u>any medications</u> you are <u>allergic</u> to:

_____ _____
_____ _____
_____ _____
_____ _____

Information regarding your family history:

Father

☐ **Living** **Current Age _____**

☐ **Deceased** **Age at death _____**

Medical problems:

_____
_____
_____

Mother

☐ **Living** **Current Age _____**

☐ **Deceased** **Age at death _____**

Medical problems:

_____
_____
_____

Family History Continued:

Brother(s)

☐ Living Current Age _____

☐ Deceased Age at death _____

Medical problems:

_____

_____

_____

Sister(s)

☐ Living Current Age _____

☐ Deceased Age at death _____

Medical problems:

_____

_____

_____

Brother(s)

☐ Living Current Age _____

☐ Deceased Age at death _____

Medical problems:

_____

_____

_____

Sister(s)

☐ Living Current Age _____

☐ Deceased Age at death _____

Medical problems:

_____

_____

_____

Social History:

Do you smoke? ☐ Yes ☐ No How many packs per day? _____ For how long? _____

Do you consume alcohol? ☐ Yes ☐ No How often? _____ How much? _____

Do you consume caffeine? (coffee, tea, soda) ☐ Yes ☐ No How much? _____

Do you use recreational drugs? ☐ Yes ☐ No How frequently? _____

Do you have any children? ☐ Yes ☐ No How many? _____ Are they healthy? ☐ Yes ☐ No

Please list the ages of your children: _____

Please list your military history, if any: _____

Are you currently employed? ☐ Yes ☐ No

What is your current occupation? _____

If retired, what was your former occupation? _____

OVERVIEW OF YOUR HEALTH

How has your general health been over the last 6 months?

☐ Excellent ☐ Fair

☐ Good ☐ Poor

If less than excellent, how so? _____

Have you had any: ☐ Fatigue
☐ Weight loss or gain over the last 6 months; how much? ___
☐ Fever
☐ Chills

Have you noticed any of the following skin conditions? (circle all that apply)

Rashes	Lumps	Hair/Nail changes
Dryness	Yellowing	Mole changes
Itching		

Do you have frequent headaches? ☐ Yes ☐ No

Have you ever experienced any head injuries? ☐ Yes ☐ No

When was your last eye exam? _____

Do you wear glasses/contacts? ☐ Yes ☐ No

Have you experienced any of the following complaints regarding your eyes? (circle all that apply)

Pain	Discharge	Vision changes
Glaucoma	Cataracts	Double vision
Seeing spots		

When was your last hearing exam? _____

Have you experienced any of the following complaints regarding your ears? (circle all that apply)

Pain	Discharge	Hearing changes
Ringing	Vertigo	Hearing loss

Do you wear hearing aids? ☐ Yes ☐ No

When was your last dental exam? _____

Have you experienced any of the following: (circle all that apply)

Hoarseness	Mouth sores
Difficulty speaking	Sore throats
Difficulty swallowing	

Do you wear dentures? ☐ Yes ☐ No

Have you noticed any lumps in your neck, or experienced swollen glands?

☐ Yes ☐ No

Have you ever had any of the following? (circle all that apply)

Neck pain	Neck Injury	Goiter	
Heart Murmurs	Rheumatic Fever	Heart Trouble	
High Blood Pressure	Temperature or color change in your hands &/or feet		
Difficulty breathing	Wheezing	Shortness of breath	
Asthma	Coughing	Coughing up blood	
Pneumonia	Bronchitis	Emphysema	
Tuberculosis	Anorexia	Diarrhea	Constipation
Hepatitis	Flatulence	Abdominal pain	Urinary Frequency
Increased urine amount	Urinary incontinence	Decreased urine amount	
Urinary tract infections	Blood in urine	Kidney Infection	Kidney Stones

Have you ever had any of the following? (circle all that apply)

Muscle Pain	Muscle weakness	Joint stiffness	Tenderness
Scoliosis	Joint swelling	Change in posture	Difficulty walking
Decreased range of motion	Numbness	Seizures	Memory Loss
Sensory Loss	Involuntary movements	Decreased concentration	
Changes in thinking	Loss of coordination	Nervousness	Anxiety
Tension	Depression	Mood swings	Personality changes
Heat/cold intolerance	Thyroid problems	Easy bruisability	
Skin pigmentation	Changes in body hair	Anemia	Easy bleeding

MALE PATIENTS

Have you had any of the following: (circle all that apply)

Penile discharge/sores	Testicular pain or masses
Change in libido	Sexual difficulty
Circumcision	Venereal disease

FEMALE PATIENTS

Have you had any of the following: (circle all that apply)

Abnormal menstrual cycles	Bleeding between menstrual cycles
Absence of menstrual cycles	Vaginal discharge/sores
Change in libido Venereal disease	

At what age did you begin menstruation? _____
What is the usual length of your period? _____ days.
What method of contraception do you use, if any? _____
What age did you reach menopause, if applicable? _____
When was your last pap smear? _____
What were the results of your last pap smear? _____
Do you perform monthly breast self-examinations? ☐ Yes ☐ No
Have you noticed any pain, discharge, masses, dimpling, or nipple changes in your breast? _____