SMART SPORTS Medicine Center

DATE_____

MEDICAL HISTORY: PLEASE CHECK THE BOX IF YOU HAVE EVER BEEN DIAGNOSED WITH THE FOLLOWING

Name: _____ **Age:** _____ **Date of Birth:** _____

Last Menstrual Period: _____ **Are you pregnant or breast feeding?**

_____

Heart

- ▢ Heart Attack / MI: _____ (Year)
- ▢ High Blood Pressure
- ▢ Irregular Heart Beat (A-Fib)
- ▢ Heart Failure/CHF
- ▢ Pacemaker
- ▢ Valve Replaced
- ▢ Defibrillator
- ▢ Heart Surgery: _____ (Year)
- ▢ Cath ▢ Bypass ▢ Stent

Lungs

- ▢ Emphysema/COPD
- ▢ On Oxygen Liters: _____
- ▢ Asthma
- ▢ Sleep Apnea ▢ Use CPAP
- ▢ Chronic Bronchitis
- ▢ Tuberculosis (TB)
- ▢ Recent Pneumonia
- ▢ Other _____

Endocrine/Kidney

- ▢ Diabetes ▢ On Insulin
- ▢ Thyroid Disease
- ▢ Liver Disease/Cirrhosis
- ▢ Kidney Failure ▢ On Dialysis
- ▢ Other _____

Brain

- ▢ Stroke
- ▢ TIA
- ▢ Seizures (In past 5 years)
- ▢ Depression/Anxiety
- ▢ Bipolar
- ▢ Alzheimer's/Dementia
- ▢ Parkinson's
- ▢ Glaucoma
- ▢ Other _____

Blood/Cancer

- ▢ Blood Clots (DVT in legs, PE)
- ▢ On Blood Thinner: _____
- ▢ Anemia
- ▢ Cancer _____ (Specify)
- ▢ Other: _____

GI System

- ▢ GI Bleed
- ▢ Ulcer
- ▢ Acid Reflux/Heartburn
- ▢ Hiatal Hernia
- ▢ Other: _____

Rheumatology

- ▢ Rheumatoid Arthritis (RA)
- ▢ Lupus (SLE)
- ▢ Fibromyalgia
- ▢ Other: _____

Infections

- ▢ HIV/AIDS
- ▢ Hepatitis B or C
- ▢ MRSA
- ▢ Current Active Infection
- ▢ Other: _____

Social History

- ▢ Smoke: _____ packs/day
- ▢ Chew Tobacco
- ▢ Alcohol use: _____ drinks/day
- ▢ Use Street Drugs/Marijuana
- ▢ Withdrawal from alcohol/drugs

Additional Medical Information:

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