PERFORMANCE
INJURY CARE & SPORTS MEDICINE

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Today's Date _____

Revised Date _____

Referred by _____

Patient Information

Last Name	First Name	Middle Name	Nickname	Social Security No.

Mailing Address	City	State	Zip	Home Phone

Physical Address (if different from above)	Cell Phone

Age	Date of Birth	☐ Male ☐ Female	Marital Status ☐ S ☐ M ☐ D ☐ W	Occupation	Work Phone / Ext

Employer (company / firm name)	Pharmacy	Email

Preferred Language	Ethnicity: ☐ White/Caucasion ☐ Hispanic/Latino ☐ Black/African American ☐ Native American ☐ Asian/Pacific Islander ☐ Other

Primary Insurance Information

Insurance Company Information	Policy ID No.	Group No.

#1 Policy Holder Name:	Date of Birth	Relationship to Patient

Address (if different from patient)	Home / Cell Phone

Employer	Occupation	Social Security Number

Secondary Insurance Information

Insurance Company Information	Policy ID No.	Group No.

#2 Policy Holder Name:	Date of Birth	Relationship to Patient

Address (if different from patient)	Home / Cell Phone

Employer	Occupation	Social Security Number

Emergency Contacts

Name	Phone	Relationship
Name	Phone	Relationship

Responsible Party (if patient is a minor child)

Last Name	First Name	Relationship to Patient	Date of Birth

Mailing Address	Social Security Number

Employer (if applicable)	Work Phone	Home / Cell Phone

Past Medical History

Medical Systems: Please check any of the following medical problems that you have now or have had in the past.

CARDIOVASCULAR
- ❑ High Blood Pressure
- ❑ Heart Attack
- ❑ Palpitations
- ❑ Irregular Heartbeat
- ❑ Heart Murmur
- ❑ Heart Valve Disorder
- ❑ Angina (chest pain)
- ❑ Rheumatic Fever
- ❑ Pacemaker
- ❑ Vascular Disease
- ❑ Other _____

RESPIRATORY
- ❑ Asthma
- ❑ Emphysema
- ❑ COPD
- ❑ Chronic Bronchitis
- ❑ Pneumonia
- ❑ Sleep Apnea
- ❑ Tuberculosis
- ❑ Chronic Cough
- ❑ Require Supplemental Oxygen
- ❑ Other _____

ABDOMINAL
- ❑ Ulcer
- ❑ Polyps
- ❑ Hiatal Hernia
- ❑ Gallstones
- ❑ Kidney Stones
- ❑ Liver Failure
- ❑ Kidney Failure
- ❑ Pancreatic
- ❑ Yellow Jaundice
- ❑ IBS
- ❑ Chrohns Inflammatory
- ❑ Bladder Incontinence
- ❑ Bowel Incontinence
- ❑ Other _____

MENTAL
- ❑ Depression
- ❑ Bipolar
- ❑ Anxiety
- ❑ Other _____

NERVE / JOINT
- ❑ Arthritis
- ❑ Lupus
- ❑ Glaucoma
- ❑ Paralysis
- ❑ Stroke
- ❑ Pain Syndrome
- ❑ Migraines
- ❑ Severe Headaches
- ❑ Seizures
- ❑ Chronic Neck Pain
- ❑ Vision Loss
- ❑ Hearing Loss
- ❑ Nerve Damage
- ❑ Neuropathy
- ❑ T-M Joint Problems (jaw)
- ❑ Other _____

BLOOD
- ❑ Bleeding Difficulties
- ❑ Clotting
- ❑ Anemia
- ❑ Leukemia
- ❑ Lymphoma
- ❑ Sickle Cell
- ❑ Prior Blood Transfusion
- ❑ Blood Clots
  - ❑ in legs
  - ❑ in lungs
- ❑ Hepatitis
  - ❑ A
  - ❑ B
  - ❑ C
- ❑ HIV
- ❑ Other _____

METABOLIC
- ❑ Diabetes
- ❑ Thyroid
- ❑ Osteoporosis
- ❑ Osteopenia
- ❑ Metabolic Syndrome
- ❑ Cushing's
- ❑ Gout / Pseudogout
- ❑ High Cholesterol
- ❑ Other _____

MISCELLANEOUS
- ❑ Alcoholism
- ❑ Chemical Dependency
- ❑ Sexually Transmitted Disease
- ❑ Cancer (specify)

Medications

Medication	Dosage	Medication	Dosage

Allergies to Medication

❑ Penicillin ❑ Iodine ❑ Sulfa ❑ Aspirin ❑ Keflex / Ancef ❑ Anti-inflammatory ❑ Novocaine Other: _____

Allergic to Latex? ❑ Yes ❑ No **Food Allergies?** (Bananas, eggs, shellfish, kiwi) Other: _____

Previous Operations

List any previous surgery including dates if known.

Type of Surgery	Date	Type of Surgery	Date

Family Medical History

Check boxes next to illnesses that have occurred in a blood-related family member.

- ❑ None
- ❑ Addiction
- ❑ Asthma
- ❑ Back Pain
- ❑ Birth Defects
- ❑ Bleeding Tendency
- ❑ Cancer
- ❑ Diabetes
- ❑ Headaches
- ❑ Other _____
- ❑ Heart Disease
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Mental Illness
- ❑ Metabolic Disorder
- ❑ Neuropathy
- ❑ Osteoarthritis
- ❑ Osteoporosis
- ❑ Pulmonary Disorder
- ❑ Rheumatoid Disorder
- ❑ Sleep Apnea
- ❑ Stroke
- ❑ Tremor
- ❑ Tuberculosis
- ❑ Vascular Disease

Social History / Habits

- ❑ **TOBACCO** ❑ Cigar ❑ Pipe ❑ Cigarettes ❑ Chew — Amount per Day _____ If Stopped, When _____
- ❑ **ALCOHOL** ❑ Beer/Ale ❑ Wine ❑ Whiskey — Amount per Day _____ If Stopped, When _____
- ❑ **OTHER** ❑ Marijuana ❑ Other Illegal Drugs — Amount per Day _____ If Stopped, When _____

Review of Symptoms

If you are experiencing any of these symptoms please check boxes.

- ❑ None
- ❑ Change in Speech
- ❑ Chest Pain
- ❑ Chills
- ❑ Chronic Cough
- ❑ Excessive Thirst
- ❑ Fainting Spells
- ❑ Fever
- ❑ Frequent Urination
- ❑ Hives
- ❑ Hot Joints
- ❑ Joint Aches
- ❑ Loss of Appetite
- ❑ Loss of Weight
- ❑ Nausea
- ❑ Night Sweats
- ❑ Rapid or Irregular Heartbeat
- ❑ Rashes
- ❑ Shortness of Breath
- ❑ Sleeping Disorder
- ❑ Sweats
- ❑ Swollen Ankles
- ❑ Upset Stomach
- ❑ Vomiting
- ❑ Weight Gain
- ❑ _____
- ❑ _____
- ❑ _____