Alpine Sports Medicine

Welcome!
Please allow us to better assist you by answering
the following prior to your first exam.
Please be complete and specific.
Thank you!

Whom may we thank for referring you to our practice? _____

Name: _____Today's Date: _____

Address: _____ Phone #: _____

Date of Birth: ___/__/_____ Age: ____ Sex: M F Education (highest) _____

Occupation: _____ How long: _____ Marital Status: S M W D Sep

Today's visit concerns which body part? _____

When did symptoms, injury, or accident begin? _____

Is this injury work related? _____

How did your symptoms begin? _____

_____

Describe your symptoms and how often you have them? _____

_____

If it was an accident or injury, where and how did it occur? _____

_____

Have you had any previous treatment for this problem? _____

_____

Have you ever had any previous x-rays, MRI's cat scans or other tests for this injury? _____

_____

Please list any and all previous surgeries and hospitalizations: _____

_____

Are you being treated for **any** medical condition and how long? _____

_____

Please circle any illnesses or conditions you have had:

Diabetes Cancer Glaucoma Heart Trouble STD Asthma
Jaundice Arthritis Hepatitis A,B,C Tuberculosis Rheumatic Fever
Kidney Disease Bleeding Tendency High Blood Pressure Aids/HIV
Thyroid Disorder

Are you currently taking any of the following medications:

Cortisone pills or shots High Blood Pressure pills Water pills
Heart Medicine Insulin

List medications you are currently taking:

Medication	Dosage	Times per day
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you have any allergies to medication or other substances? _____

_____

Do you smoke? Y N Chew? Y N If yes, how much? _____ For how long? _____

Do you drink Alcohol? Y N If yes, how much? _____ What type? _____

Number of Pregnancies _____ Are you taking birth control pills? _____

Height _____ Weight _____ How long have you been at this weight? _____

Please circle any illnesses which have occurred in any of your blood relatives:

Diabetes Cancer Heart Disease Tuberculosis Stroke
Bleeding Tendencies Kidney Trouble High Blood Pressure

Other (describe): _____

_____

Patient Signature: _____ Date: _____

Reviewed By: _____ Date: _____