

# 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:

<u>Medication</u>	<u>Dosage</u>	<u>Times per day</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

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: \_\_\_\_\_

