



REVIEW OF SYSTEMS

Circle any problems, illnesses or injuries that you have had

- General:** malaise, fever, night sweats, chills, weight gain, weight loss
- Eyes:** loss of vision, double vision, cataracts
- Ears:** hearing loss, ringing in your ears, dizziness
- Nose:** sinus infections, frequent bloody nose
- Throat:** frequent sore throat, strictures, hoarseness
- Heart:** chest pain, irregular heart beat, heart attacks, swelling of leg
- Lung:** difficulty in breathing, shortness of breath, pneumonia, bronchitis, asthmas, coughing up blood, tuberculosis
- Gastrointestinal:** heartburn, stomach pain, blood in bowel movements, vomiting blood, ulcers, inability to control bowel movements
- Genitourinary:** blood in the urine, burning when urinating, sexually transmitted diseases, discharge, inability to control urination
- Gynecologic:** female problems, uterus removed, ovaries removed, currently taking birth control pills or estrogen, heavy or irregular mense, pain on intercourse, pain during menstrual cycle
- Back:** ruptured disc, car accidents, chronic pain, fractures, strains
- Neck:** ruptured disc, car accidents, chronic pain, fractures, strains
- Musculoskeletal:** muscle or bone diseases, broken bones, dislocations, osteoporosis, joint instability, chronic pain of an extremity
- Neurologic:** loss of sensation, abnormal sensation, tingling, numbness, loss of motor function, decreased strength
- Skin:** skin color changes, loss of pigmentation, abnormal moles, bleeding from moles, moles or dark spots increasing in size
- Psychiatric:** nervous breakdowns, seeing or hearing things that aren't there, depression, abnormal behavior, taking medication for a psychiatric condition

Patient Signature _____ Date: _____



MEDICAL HISTORY

Name: _____ Age: _____

Family History:

	Mother	Father	Mother's Parents	Father's Parents
Heart attack	<input type="checkbox"/> Age_____	<input type="checkbox"/> Age_____	<input type="checkbox"/> Age_____	<input type="checkbox"/> Age_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lung Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Problems with anesthesia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/> Type_____	<input type="checkbox"/> Type_____	<input type="checkbox"/> Type_____	<input type="checkbox"/> Type_____
Cancer	<input type="checkbox"/> Type_____	<input type="checkbox"/> Type_____	<input type="checkbox"/> Type_____	<input type="checkbox"/> Type_____

Social History: Do you

Smoke Yes No Packs Per day_____ Years Smoked _____

Drink Yes No Drinks Per day_____

Abuse drugs Yes No Type_____

Work (what type of work) _____

Are you married? Yes No

Childhood Illnesses: (check ✓ if applicable)

- Measles
- Rubella
- Mumps
- Chicken Pox
- Other _____

Adult Illnesses: (check ✓ if applicable)

- Diabetes
- Lung Disease
- Hepatitis-
- Heart Attack
- Other _____
- Arrythmia
- AIDS

Injuries: (List all head injuries, broken bones, back injuries, and date)

Prior Surgeries: (List type, date and any complications)

please PRINT clearly

Sport: _____

PRE-PARTICIPATION PHYSICAL EXAMINATION FORM

Today's Date: _____

Name: _____ Date of Birth: _____ / _____ / _____

SS#: _____ - _____ - _____ Right / Left handed (circle one) Age: _____

Home Address: _____
(City) (State) (Zip)

School Address: _____
(City) (State) (Zip)

Cell Phone: (____) _____ Home Phone: (____) _____

Emergency Contact: _____ Relation: _____ Emergency Phone: (____) _____

Do you have any of the following problems or a history of? (circle any that apply)

High Blood Pressure Latex Allergy Anemia Asthma Heart Problems Mitral Valve Prolapse Sleep Apnea
Seizures Angina Irregular Heart Beat History of Stroke Diabetes Thyroid Condition Mono Shingles

- | | | | | |
|---|---|-----|----|---|
| 1 | Have you ever been hospitalized? | Yes | No | When/Why: _____ |
| 2 | Have you ever had surgery? | Yes | No | When/Why: _____ |
| 3 | Currently taking medications? | Yes | No | List: _____ |
| 4 | Do you have any allergies?
(pollen, drug, food, bee stings, etc) | Yes | No | List: _____ |
| 5 | Do you have asthma? | Yes | No | List medications: _____ |
| 6 | Do you have diabetes? | Yes | No | Shots / Pills / Diet control List medications:
_____ |
| 7 | Do you have epilepsy? | Yes | No | List medications: _____ |
| 8 | Have you ever had a concussion? | Yes | No | How many? _____ When: _____ |
| 9 | Ever had a staph infection/MRSA? | Yes | No | When: _____ |

please PRINT clearly