UAB Sports Medicine Patient Information

Please Fill List Out **Completely**

Patient Name:_____
(Last) (First) (Middle)

Date of Birth:_____ Social Security Number:_____

Home Address:_____

City:_____ State:_____ Zip Code:_____

Home Phone:_(_____)_____ Cell Phone:_(_____)_____

Primary Care Physician:_____ Phone:_(_____)_____

*If you have Medicaid, you **MUST** list a physician and phone number*

Primary Responsible Party:

Name:_____ Relationship to Patient:_____ Date of Birth:_____

Address:_____

Home Phone:_(_____)_____ Cell Phone:_(_____)_____

Employer:_____ Phone:_(_____)_____

Secondary Responsible Party:

Name:_____ Relationship to Patient:_____ Date of Birth:_____

Phone:_(_____)_____ Cell/Work:_(_____)_____

Primary Insurance:_____

Policy Holder Name:_____ Date of Birth:_____

Policy Number:_____ Group Number:_____

Policy Number SSN:_____

Secondary Insurance:_____

Policy Holder Name:_____ Date of Birth:_____

Policy Number:_____ Group Number:_____

Policy Number SSN:_____

DATE:_____

UAB Sports Medicine Medical History Form

To ensure you receive a complete and thorough evaluation, please provide us with the important background information on the following form. If you do not understand a question, leave it blank and your physician or physical therapist will assist you. Thank you!

Name:_____ **Age:**_____ **Height:**_____ **Weight:**_____

Gender: M or F **Race:**_____ **Sport/Occupation:**_____

School:_____ **Grade:**_____ **Leisure Activities:**_____

Date of Injury:_____ **How did your injury occur?**_____

Location of Injury: (Please Circle One)

Right or **Left**

Shoulder ☐ **Elbow** ☐ **Wrist** ☐ **Hand** ☐ **Hip** ☐ **Knee** ☐ **Ankle** ☐ **Foot** ☐ **Other:**_____

Allergies:

List any medications you are allergic to:_____

Do you have any food allergies?_____

Are you latex sensitive?_____

Have you EVER been diagnosed as having any of the following conditions?

YES NO **Cancer:** If yes, describe what kind:_____
YES NO **Heart Problems**
YES NO **High Blood Pressure**
YES NO **Circulation Problems**
YES NO **Asthma**
YES NO **Emphysema/Bronchitis**
YES NO **Chemical Dependency** (i.e. Alcoholism)
YES NO **Thyroid Problems**
YES NO **Diabetes**
YES NO **Multiple Sclerosis**
YES NO **Rheumatoid Arthritis**
YES NO **Other Arthritic Conditions:** Please Explain:_____
YES NO **Depression**
YES NO **Tuberculosis**
YES NO **Stroke**
YES NO **Kidney Disease**
YES NO **Anemia**
YES NO **Epilepsy**
YES NO **Multiple Birth**
YES NO **Other:**_____

During the past month, have you been feeling down, depressed, or hopeless? YES NO

During the past month, have you been bothered by having little interest or pleasure in doing things? YES NO

Do you feel unsafe at home or has anyone hit you or try to injure you in any way? YES NO

(FOR WOMEN) Are you currently pregnant or think you might be pregnant? YES NO

Please list any conditions for which you have been hospitalized and/or abd surgeries, including the approximate date and reason for the surgery or hospitalization:

DATE:	**REASON FOR SURGERY/HOSPITALIZATION:**
_____	_____
_____	_____
_____	_____

Has anyone in your immediate family (parents, brothers, sisters) ever been treated for the following?

- **YES NO Diabetes**
- **YES NO Tuberculosis**
- **YES NO Heart Disease**
- **YES NO Stroke**
- **YES NO Kidney Disease**
- **YES NO Mental Illness**
- **YES NO Cancer**
- **YES NO Arthritis**
- **YES NO Anemis**
- **YES NO Headaches**
- **YES NO Epilepsy**
- **YES NO Chemical Dependency** (i.e. Alcoholism)

Which OVER THE COUNTER medication have you taken in the last week?

- **YES NO Aspirin**
- **YES NO Tylenol**
- **YES NO Antacids**
- **YES NO Laxatives**
- **YES NO Decongestants**
- **YES NO Antihistamines**
- **YES NO Advil/Motrin/Ibuprofen**
- **YES NO Vitamins/Minerals/Supplements**
- **YES NO Other:_____**

Please list any PRESCRIPTION medications you are currently taking (including pills, injections, and/or skin patches) Please include the dose of the medication

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

How many cups of coffee or caffeine-containing beverages do you drink per day? _____

Do you smoke YES NO If yes, how many cigarettes do you smoke per day? _____

How many days per week do you drink alcohol? _____

Have you recently noticed any of the following?

- **YES NO Weight Gain/Loss**
- **YES NO Fatigue**
- **YES NO Fever/Chills/Sweats**
- **YES NO Nausea/Vomiting**
- **YES NO Weakness**
- **YES NO Numbness/Tingling**

What activities would you like to return to performing? _____

What is your immediate personal goal? _____

_____ _____

Patient Signature Date Physician Signature Date