EL DORADO HILLS
SPORTS MEDICINE

(office use) Medical Record # ________________

Height: ____ft ____in | Weight:______lbs | BP: _____/_____ | Pulse: _____

Visit History Form

Patient name: ____ Date of birth: ___________ Age: _____

Current Sport/Activity: ____

Other Sport(s)/Activity(ies) you enjoy: ____

____

History of Present Injury/Illness/Issue

Date of injury/onset: ____________________________ Which side? __ Left __ Right __ Bilateral

Please describe your current problem: ____

____

What makes this worse? ____

What makes this better? ____

What treatments have you tried? ____

Have you injured this area before? If yes, please describe: ___________________________________

Associated symptoms:

Numbness	_____ Yes	_____ No	Weakness	_____ Yes	_____ No
Tingling	_____ Yes	_____ No	Redness	_____ Yes	_____ No
Swelling	_____ Yes	_____ No	Fever	_____ Yes	_____ No
Bruising	_____ Yes	_____ No	Chills	_____ Yes	_____ No

Please rate your pain at its WORST ______ /10; at its BEST ______ /10; and TODAY ______ /10.

Social History

Do you drink alcohol? _____ Yes _____ No If yes, # drinks per week (on average): _______

Do you smoke tobacco? _____ Yes _____ No If yes, # packs per day (on average): _______

How often do you engage in moderate physical activity (elevated heart rate for at least 30 minutes)?

_____ Occasionally (1-2 days per week)

_____ Frequently (3-5 days per week)

_____ Regularly (6+ days per week)