Midwest Sports Medicine Institute, S.C.

2521 Allen Blvd.
Middleton, WI 53562

patient label

History Intake Form

Name: ______________________________ Birthdate: __________ Today's date: ________

Description of problem: ____

Date of Onset ____________ Were you injured? ❒ yes ❒ no

Referring Physician: ____________________ Your primary care physician: ____________________

Past Medical History:____

____

____

Past Surgical History:____

____

Current Medications: ____

____

Medication Allergies: ____

Do you have any of the following:

❒ fevers
❒ chills
❒ night sweats
❒ weight loss
❒ fatigue
❒ joint swelling
❒ depression
❒ Ear/nose/mouth/throat problem
❒ asthma
❒ allergies
❒ wheezing
❒ shortness of breath
❒ chest pain
❒ palpitations
❒ urinary symptoms
❒frequent headaches
❒ loss of consciousness
❒ numbness or tingling
❒ loss of bowel or bladder control
❒ muscle weakness
❒ loss of coordination
❒ recent loss of vision
❒ frequent infections
❒ skin rash, other skin problem
❒ abdominal pain
❒ diarrhea
❒ loss of appetite
❒ history of stress fracture
❒ bleeding problem
❒ menstrual irregularities

Family History:

❒ osteoarthritis
❒ rheumatoid arthritis
❒ heart disease
❒ high blood pressure
❒ osteoporosis
❒ high cholesterol
❒ stroke
❒ inflammatory bowel disease (ulcerative colitis, Crohn's disease)
❒ thyroid disease
❒ chronic back problems
❒ cancer; type: ____________________
❒ diabetes
❒ tuberculosis

Social History:

Sports you participate in:____

Is athletic training a major part of your life? __________ Do you get regular exercise? __________

Tobacco use: never ___ smoker ____ (packs/day ____) former smoker ____ (date stopped: _______)

Occupation: ______________________________