

**THE SPORTS MEDICINE CLINIC**  
**PATIENT HEALTH QUESTIONNAIRE**

Patient Name \_\_\_\_\_  
(please print)  
Today's Date \_\_\_\_\_  
Patient Signature \_\_\_\_\_

**MEDICAL HISTORY**

**What is your height?** \_\_\_\_\_ **What is your weight?** \_\_\_\_\_ **Your Age?** \_\_\_\_\_

**Have you had any Serious Injuries / Illnesses / Medical Problems?** \_\_\_\_\_ **Date:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Have you been Hospitalized or had Surgery?** \_\_\_\_\_ **Date:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Medications/Vitamins** \_\_\_\_\_  
\_\_\_\_\_

**Known Allergies to Medicine (please list)** \_\_\_\_\_  
\_\_\_\_\_

**Immunizations:** (last date of) Flu \_\_\_\_\_ Tetanus \_\_\_\_\_ Pneumovax \_\_\_\_\_

**FOR WOMEN ONLY:**

# of pregnancies \_\_\_\_\_ #of miscarriages \_\_\_\_\_ #of abortions \_\_\_\_\_ Age at 1st menstrual cycle? \_\_\_\_\_  
Age at menopause \_\_\_\_\_ Date of last pap smear \_\_\_\_\_ Date of last mammogram \_\_\_\_\_

**PATIENT SOCIAL HISTORY**

Marital Status: Single \_\_\_\_\_ Married \_\_\_\_\_ Separated \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_  
Current Occupation: \_\_\_\_\_  
Use of Alcohol: Never \_\_\_\_\_ Rarely \_\_\_\_\_ Moderate \_\_\_\_\_ Daily \_\_\_\_\_  
Use of Caffeine, Cups per Day: Coffee \_\_\_\_\_ Sodas \_\_\_\_\_ Tea \_\_\_\_\_  
Use of Tobacco: Never \_\_\_\_\_ Previously, but quit \_\_\_\_\_ Current pack/day \_\_\_\_\_  
Use of Drugs: Never \_\_\_\_\_ Type/Frequency \_\_\_\_\_  
Exercise: Never \_\_\_\_\_ Rarely \_\_\_\_\_ Weekly \_\_\_\_\_ Daily \_\_\_\_\_ Type of Exercise: \_\_\_\_\_

**DO YOU HAVE A "Living will"?** Yes \_\_\_\_\_ No \_\_\_\_\_

Would you like more information about Health Care Directives and Durable Power of Attorney? Yes \_\_\_\_\_ No \_\_\_\_\_

**FAMILY MEDICAL HISTORY**

Do you know of any blood relative who has or had: (indicate relationship)

Arthritis	_____	Heart Disease	_____
Asthma/Allergies	_____	High Blood Pressure	_____
Bleeding Tendency	_____	Mental Illness	_____
Cancer	_____	Reaction to Anesthesia	_____
Diabetes	_____	Stroke	_____
Genetic Disorder	_____	TB	_____

**ARE YOU EXPERIENCING ANY OF THE FOLLOWING:**

**CONSTITUTIONAL SYMPTOMS**

Unexplained weight gain or loss..... yes no  
 Fever or chills..... yes no  
 Night sweats/Hot flashes..... yes no  
 Fatigue ..... yes no

**HEMATOLOGIC/LYMPHATIC**

Bleeding or bruising tendency..... yes no  
 Anemia ..... yes no

**EYES**

Blurred or double vision..... yes no

**EARS/NOSE/MOUTH/THROAT**

Hearing loss or ringing ..... yes no  
 Earaches or drainage..... yes no  
 Chronic sinus problem or rhinitis..... yes no  
 Recurrent nose bleeds ..... yes no  
 Bleeding gums..... yes no  
 Sore throat or voice change (hoarseness) ..... yes no  
 Hay fever ..... yes no

**CARDIOVASCULAR**

Heart trouble..... yes no  
 Chest pain or angina pectoris..... yes no  
 Palpitation (fast or irregular heart beat)..... yes no  
 Shortness of breath while walking or lying flat .. yes no  
 Swelling of feet, ankles or hands..... yes no  
 High blood pressure ..... yes no  
 DVT, blood clot or pulmonary embolism..... yes no  
 Have you ever been on IV antibiotics?..... yes no

**RESPIRATORY**

Chronic or frequent coughs ..... yes no  
 Spitting up blood..... yes no  
 Shortness of breath ..... yes no  
 Asthma or wheezing..... yes no

**GASTROINTESTINAL**

Loss of appetite..... yes no  
 Change in bowel movement..... yes no  
 Nausea or vomiting ..... yes no  
 Frequent Diarrhea ..... yes no  
 Painful bowel movement or constipation..... yes no  
 Rectal bleeding or blood in stool ..... yes no  
 Abdominal pain or heartburn..... yes no  
 Peptic ulcer (stomach or duodenal)..... yes no  
 Trouble swallowing..... yes no

**GENITOURINARY**

Frequent urination ..... yes no  
 Burning or painful urination ..... yes no  
 Blood in urine ..... yes no  
 Urination at night (> 1/night)? ..... yes no  
 Incontinence or dribbling ..... yes no  
 Decrease in urine stream ..... yes no  
 Kidney stones..... yes no  
 Sexual difficulty ..... yes no  
 Slow to start/stop urination ..... yes no  
 Female - pain with periods ..... yes no  
 Female - irregular periods ..... yes no  
 Female - Contraception type \_\_\_\_\_  
 Female - Days in menstrual cycle \_\_\_\_\_  
 Female - Date of last menstrual period \_\_\_\_\_

**MUSCULOSKELETAL**

Joint pain ..... yes no  
 Joint stiffness or swelling..... yes no  
 Back pain..... yes no

**INTEGUMENTARY (skin, breast)**

Rash or itching ..... yes no  
 Breast pain ..... yes no  
 Breast lump ..... yes no  
 Breast discharge ..... yes no

**NEUROLOGICAL**

Frequent or recurring headaches ..... yes no  
 Light headed or dizzy ..... yes no  
 Convulsions or seizures ..... yes no  
 Numbness or tingling sensations ..... yes no  
 Paralysis..... yes no  
 Memory loss or confusion ..... yes no

**ENDOCRINE**

Thyroid disease ..... yes no  
 Diabetes ..... yes no  
 Other glandular or hormone problem ..... yes no

**OTHER**

Nervousness ..... yes no  
 Depression/Anxiety/Panic ..... yes no  
 Insomnia..... yes no

Other concerns not noted above:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Physician Initials: \_\_\_\_\_

Date: \_\_\_\_\_