# TMI Sports Medicine Medical History Form

Name: ____________________________________________ SS# _________________ Date: ________________

DOB: ______________________ Age: ____________

Chief Complaint: ____________________________________________________________________________________________

**Family History**

| | Father | Mother | Father's Parents | Mother's Parents | Sibling | Children |
|---|---|---|---|---|---|---|
| Heart Disease | ▫ | ▫ | ▫ | ▫ | ▫ | ▫ |
| High Blood Pressure | ▫ | ▫ | ▫ | ▫ | ▫ | ▫ |
| Stroke | ▫ | ▫ | ▫ | ▫ | ▫ | ▫ |
| Cancer | ▫ | ▫ | ▫ | ▫ | ▫ | ▫ |
| Glaucoma | ▫ | ▫ | ▫ | ▫ | ▫ | ▫ |
| Diabetes | ▫ | ▫ | ▫ | ▫ | ▫ | ▫ |
| Epilepsy/(Convulsions) | ▫ | ▫ | ▫ | ▫ | ▫ | ▫ |
| Bleeding Disorder | ▫ | ▫ | ▫ | ▫ | ▫ | ▫ |
| Kidney Disease | ▫ | ▫ | ▫ | ▫ | ▫ | ▫ |
| Thyroid Disease | ▫ | ▫ | ▫ | ▫ | ▫ | ▫ |
| Mental Illness | ▫ | ▫ | ▫ | ▫ | ▫ | ▫ |
| Osteoporosis | ▫ | ▫ | ▫ | ▫ | ▫ | ▫ |

DRUG ALLERGIES __________________________
__________________________________________
__________________________________________
__________________________________________
__________________________________________

CURRENT MEDS ____________________________________
__________________________________________________
__________________________________________________
__________________________________________________
__________________________________________________

***HOSPITALIZATIONS OR SURGERIES***

| Reason | Date | Reason | Date |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**Medical History**

▫Headache
▫Shortness of breath
▫Heart Palpitations
▫Heart Murmur
▫Chest Pain
▫Frequent Infections
▫Polio
▫Lactose Intolerance
▫Gallbladder Disease
▫ Ulcer
▫ Allergies/Hay Fever
▫Gout
▫Rheumatic Fever
▫Diphtheria
▫ Venereal Disease
▫ Bowel Irregularity
▫ Bronchitis
▫ Dizziness/Fainting
▫ Depression
▫Mumps
▫Tetanus
▫ Incontinence
▫ GI Disorder
▫ Asthma
▫ Nervousness
▫Scarlet Fever
▫Peripheral Vascular Disease
▫ Sexual/Menstrual Dysfunction
▫ Anemia
▫ Arthritis
▫ Osteoporosis
▫Hepatitis
▫Chronic Rash
▫Rubella

▫Other ____________________________________________________________________________
__________________________________________________________________________________

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***WOMEN ONLY:*** PREGNANT ▫ YES ▫ NO ***PLANNING PREGNANCY*** ▫ YES ▫ NO

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***HABITS***

▫Smoke: ▫Packs Daily ______
▫How Long _______
▫Interested in Stopping
▫Exercise Routine: __________
__________________________
__________________________

▫Coffee: Cups Daily _______________
Other Caffeine ____________
▫Alcohol: Type ____________________
Amount _________________
▫Diet: Salt Intake __________________
Fat Intake __________________

▫Sleep: Difficulty falling asleep ▫ YES ▫ NO
Continuity Disturbances ▫ YES ▫ NO
Snoring ▫ YES ▫ NO
Early Morning Awakening ▫ YES ▫ NO
Daytime Drowsiness ▫ YES ▫ NO
Other ▫ YES ▫ NO