TABEGUACHE Sports Medicine
A division of Primary Care Partners

FOR OFFICE USE ONLY-
Appointment Date: _____
Appointment Time: _____
Provider: _____
Scheduler's Initials: _____

Please complete all information on this form to the best of your knowledge. If none in a particular section, write N/A or none. Pediatric Patients (0-17 years of age); Adult Patients (18+ years of age)

**Patient Name: _____ Date of Birth: _____ Date Completed: _____**

**Pediatric Sections:** For patients 0-17 years of age **Adult Sections:** For patients 18+ years of age

Who is completing this form? □ Mother □ Father □ Grandparent □ Foster parent
□ Self □ Other_____

## Pediatric Medical History (for patients 0-17 years of age)

Please check all that apply:

| | | | | |
|---|---|---|---|---|
| □ Acne | □ Cancer:_____ | □ Headache | □ Joint Problems | □ Psych. Disorder |
| □ ADD | □ Chickenpox | □ Hearing Loss | □ Murmurs | □ Strep Throat |
| □ ADHD | □ Constipation | □ Heart Surgery | □ Chronic Ear Infections | |
| □ Anemia | □ Depression | □ Heart Disease | □ Mononucleosis | |
| □ Asthma | □ Diabetes | □ Hepatitis | □ Seizures | |
| □ Autism | □ Emotional Problems | □ Jaundice | □ Skin Problems | |

Other(s):_____

## Adult Medical History (for patients 18+ years of age)

Please check all that apply:

| | | | | |
|---|---|---|---|---|
| □ Alcohol Abuse | □ Cancer:_____ | □ Heart Disease | □ Liver Disease | □ Psych. Disorder |
| □ Alzheimer's | □ Chronic Pain | □ Heart Murmur | □ Lung Disease | □ Seizure Disorder |
| □ Anemia | □ C.O.P.D. | □ Heart Surgery | □ Memory Problems | □ STD:_____ |
| □ Arthritis | □ Depression | □ Heartburn | □ Migraines | □ Skin Problems |
| □ Asthma | □ Diabetes | □ High Cholesterol | □ M.S. | □ Stroke |
| □ Blood Clot | □ Drug Abuse | □ Hypertension | □ Muscle Problems | □ Thyroid |
| □ Blood Disease | □ Ear Problems | □ Joint Problems | □ Parkinson's | |
| □ Bowel Disease | □ Eye Problems | □ Kidney Disease | □ Peripheral Vascular Disease | |

□ Other(s):

**Patient Allergies:**

| | | | |
|---|---|---|---|
| □ Sulfa Drugs | Reaction:_____ | □ Food/Insect | Reaction:_____ |
| □ Penicillin | Reaction:_____ | □ None | |
| □ Codeine | Reaction:_____ | | |
| □ Other:_____ | Reaction:_____ | | |

**Immunizations:**

For Pediatric Patients (0-17 years of age) please attach current immunization records.
Adult Patients; list month/year of last immunization

| | | |
|---|---|---|
| Flu:_____ | Hepatitis B:_____ | Shingles:_____ |
| Gardasil:_____ | Meningitis:_____ | Tetanus:_____ |
| Hepatitis A:_____ | Pneumovax:_____ | Other:_____ |

**Pediatric Surgeries:** (check all your child or you have had; circle **R**ight or **L**eft side if applicable)

- □ Fracture Repair:_____
- □ Inguinal Hernia Repair
- □ Myringotomy (Ear Tubes)
- □ Congenital Heart Disease
- □ Tonsillectomy (Tonsils)
- □ Umbilical Hernia Repair
- □ Cholecystectomy (Gall Bladder)

Other:_____

- □ Adenoidectomy (Adenoids)
- □ Appendectomy (Appendix)

**Adult Surgeries:** (check all you have had; circle **R**ight or **L**eft side if applicable)

- □ Appendectomy
- □ Breast Augmentation
- □ Breast Biopsy: **R** or **L**
- □ Breast Lumpectomy: **R** or **L**
- □ Breast Mastectomy: **R** or **L**
- □ Thyroidectomy
- □ Vasectomy
- □ Cataract Removal: **R** or **L**
- □ Cholecystectomy
- □ Coronary Artery Bypass
- □ # of vessels_____
- □ Hysterectomy (Total)
- □ Tonsillectomy
- □ Other:_____
- □ Hysterectomy (Partial)
- □ Inguinal Hernia Repair: **R** or **L**
- □ Laminectomy (Cervical)
- □ Laminectomy (Lumbar)
- □ Prostatectomy (Prostate)
- □ Umbilical Hernia Repair

**Diagnostic Studies:** list month/year of last diagnostic study as well as the reason for each study

X-Ray:_____
CT Scan:_____
MRI:_____
Stress Test:_____
Ultrasound:_____
Other:_____

**Health Maintenance:**

Bone Density:_____
Last Pap:_____
Mammogram:_____
Colonoscopy:_____
Cholesterol:_____
PSA:_____
Eye Exam:_____
Dental Exam:_____
Podiatry Exam:_____

**Present Medications:** List name and dose of the medications you are currently taking (include supplements and over the counter medications you are taking as well)

| Medication: | Dose: |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

**Family History:**

Does your mother, father, grandparents, brothers, sisters, aunts, uncles, or children have any of the following? If yes, who? If family history is unknown, please check unknown.

| | | | |
|---|---|---|---|
| □ Yes | □ No | Cancer | If yes who? _____ |
| □ Yes | □ No | Diabetes | If yes who? _____ |
| □ Yes | □ No | Drinking Problems | If yes who? _____ |
| □ Yes | □ No | Heart Problems | If yes who? _____ |
| □ Yes | □ No | High Blood Pressure | If yes who? _____ |
| □ Yes | □ No | Learning Problems | If yes who? _____ |
| □ Yes | □ No | Lung Problems (Asthma) | If yes who? _____ |

| | | | |
|---|---|---|---|
| □ Yes | □ No | Mental Illness (Depression) | If yes who? _____ |
| □ Yes | □ No | Anemia | If yes who? _____ |
| □ Yes | □ No | C.O.P.D. | If yes who? _____ |
| □ Yes | □ No | Hepatitis | If yes who? _____ |
| □ Yes | □ No | H.I.V. | If yes who? _____ |
| □ Yes | □ No | History of Blood Clots | If yes who? _____ |
| □ Yes | □ No | Jaundice | If yes who? _____ |
| □ Yes | □ No | Kidney Disease | If yes who? _____ |
| □ Yes | □ No | Stroke | If yes who? _____ |
| □ Yes | □ No | Sleep Apnea | If yes who? _____ |
| □ Yes | □ No | Stents | If yes who? _____ |
| □ Other:_____ | | | □ Unknown:_____ |

Pediatric Social History (for patients 0-17 years of age):

**Family Habits:**

Primary Language Spoken? _____ Who lives in the home with the child? _____

**Environment/Home:**

| | | | | | |
|---|---|---|---|---|---|
| Where is the child living now? | □ Apartment | □ House | □ Shelter | □ Other_____ | |
| Are there guns in the home? | □ Yes | □ No | Are they locked up? _____ | | |
| Does anyone in the household smoke? | □ Yes | □ No | Indoors or Outdoors? _____ | | |
| Does anyone in the household drink alcohol? | □ Yes | □ No | How much per week? _____ | | |
| Is there any drug use in the household? | □ Yes | □ No | What type of drug? _____ | | |

Adult Social History (for patients 18+ years of age):

**Substance Abuse:**

| | | | |
|---|---|---|---|
| Cigarette smoking? | □ Yes □ No | Packs per day? _____ | How long? _____ |
| Past smoking? | □ Yes □ No | What year did you quit? _____ | |
| Chewing tobacco? | □ Yes □ No | Smoke Exposure? | □ Yes □ No |
| Do you drink alcohol? | □ Yes □ No | How many drinks per week? _____ | |
| Any drug use? | □ Yes □ No | What type of drug? _____ | |

**Living Situations:**

Who do you live with? □ Alone □ Spouse □ Parents □ Partner □ Caregiver □ Roomate(s)
□ Other:_____

**Communication Needs:**

Do you have hearing loss, wear hearing aids or have deafness? □ Yes □ No
If yes, describe: _____
Do you have visual loss, wear glasses or contacts, or have blindness? □ Yes □ No
If yes, describe: _____

**Legal Guardian/Health Care Proxy: (please provide copies to the office)**

Do you have a Legal Guardian or Healthcare Power of Attorney? □ Yes □ No
If yes, whom? _____
Do you have a living will or advanced directives? □ Yes □ No
Do you have a DNR order? □ Yes □ No

**Current Symptoms:**

Adults (Patients 18+) please check all symptoms that you are currently experiencing.
Pediatric Patients (Patients 0-17) please check all the symptoms you or your child currently have.

**General:**
- □ Chills
- □ Fatigue
- □ Fever
- □ Night Sweats
- □ Sleep Difficulties
- □ Weight Gain
- □ Weight Loss

**Skin:**
- □ Bruising
- □ Changes in Moles
- □ Dryness
- □ Hair Loss
- □ Itching/ Rash
- □ New Lesions
- □ Scalp Problems
- □ Yellowing of Skin

**Psychiatric:**
- □ Anxiety
- □ Depression
- □ Mood Swings
- □ Change in Sleep

**Neck:**
- □ Neck Mass
- □ Neck Pain
- □ Swollen Glands

**Respiratory:**
- □ Cough
- □ Coughing up Blood
- □ Shortness of Breath
- □ Sputum Production
- □ Wheezing
- □ Low Exercise Tolerance

**Breast:**
- □ Breast Pain
- □ Breast Lump
- □ Nipple Discharge

**Gastrointestinal:**
- □ Abdominal Pain
- □ Black, Tarry Stool
- □ Constipation
- □ Diarrhea
- □ Difficulty Swallowing
- □ Nausea/Vomiting
- □ Rectal Bleeding
- □ Vomiting Blood

**Female Genitourinary:**
- □ Pelvic Pain
- □ Urinary Complaints
- □ Vaginal Bleeding Problems
- □ Vaginal Discharge

**Male Genitourinary:**
- □ Blood in Urine
- □ Impotence
- □ Penile Discharge
- □ Urination Difficulty

**Musculoskeletal:**
- □ Joint Pain
- □ Muscle Pain
- □ Muscle Weakness
- □ Swelling of Area: _____

**Neurological:**
- □ Dizziness
- □ Fainting Spells
- □ Headaches
- □ Memory Problems
- □ Numbness
- □ Seizures
- □ Tremors
- □ Weakness

**Endocrine:**
- □ Appetite Changes
- □ Excessive Thirst
- □ Hot Flashes

**Hematology:**
- □ Anemia
- □ Blood Clots in Legs
- □ Blood Clots in Lungs

**Cardiovascular:**
- □ Chest Pain
- □ Chest Pressure
- □ Palpitations

**Eye/Ear/Nose/Throat:**
- □ Earache
- □ Gums Bleeding
- □ Hearing Decreased
- □ Nose Bleeds
- □ Ringing in Ears
- □ Runny Nose
- □ Sinus Pain
- □ Sore Throat
- □ Throat Hoarseness
- □ Visual Disturbances
- □ Seasonal Allergies

Adult Patients: (18+ years of age)

How would you rate your overall health? □ Good □ Fair □ Poor

Pediatric Patients: (0-17 years of age)

How would you rate your child's or your overall health? □ Good □ Fair □ Poor

Do you have concerns about your child's behavior or development? □ Yes □ No

If yes, what are your concerns? _____

**Specialists:**

Is the patient currently seeing any specialists?

Yes No If so, please list the specialty and physician.

Specialty: _____ Physician: _____

**Pharmacy Information:**

Preferred Pharmacy: _____

Address: _____

Do you use a mail order pharmacy? □ Yes □ No If yes, please provide the following:
Name: _____
Address: _____
Phone Number: _____

---

**Sports Medicine Patients:**

Please fill this section out only if you are being seen for a musculoskeletal injury in the sports medicine clinic!

**History of Complaint:**

What is the reason for your visit today? _____
What area(s) of the body is involved? _____ When did it start? _____
Explain how and where the problem or injury occurred and the symptoms: _____
What makes the symptoms better? _____ What makes the symptoms worse? _____
Are your symptoms getting…? □ Better □ Worse □ Staying the Same
Have you had previous injuries to this area? □ Yes □ No If yes, when? _____

**Previous Treatment:**

Have you been treated by any other physician or hospital for this injury? □ Yes □ No
If yes, where? _____ When? _____
Have you had surgery for this injury? □ Yes □ No
If yes when? _____ Where? _____
Have you done physical therapy for this injury? □ Yes □ No Where? _____
Have you tried injections? □ Yes □ No □ Viscosupplementation □ Cortisone □ Other:_____
Have you tried: □ Bracing □ Cane □ Crutches □ Other: _____
Have you had: □ X-rays □ MRI □ Bone Scan □ EMG/NVC □ CT Scan □ Other:_____

**Work History:**

Occupation:_____ Are you retired: □ Yes □ No
If you are working is it modified in any way? □ Yes □ No How? _____
What are your restrictions? _____

---