



SIEVERS SPORTS MEDICINE & FAMILY PRACTICE

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Name _____ Today's Date _____

Male Female Age _____ Birthdate _____ Date of last physical examination _____
mm / dd / yyyy

Marital status _____ Occupation _____

What is the reason for your visit today? _____

HEALTH MAINTENANCE *List the most recent date for each of the following:*

WOMEN ONLY

_____ Menstrual period
_____ Mammogram
_____ Pap smear

BOTH MEN AND WOMEN

_____ Cholesterol testing _____ Pneumonia vaccine
_____ Colonoscopy _____ Bone Density (DEXA)
_____ Tetanus booster

MEN ONLY

_____ Digital rectal exam
_____ PSA (prostate blood test)

CONDITIONS *Check conditions you currently have or have had in the past*

- | | | | | |
|--|--|--|---|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> GERD (reflux) | <input type="checkbox"/> HIV positive | <input type="checkbox"/> Rhinitis |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Bulimia | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Sexually transmitted infection |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> CAD / heart disease | <input type="checkbox"/> Goiter | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Cancer, type _____ | <input type="checkbox"/> Gout | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Suicide attempt |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Chemical dependency | <input type="checkbox"/> Headaches | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Thyroid problem |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Depression | <input type="checkbox"/> Heart attack | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Prostate problem | <input type="checkbox"/> Ulcer(s) |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Emphysema/COPD | <input type="checkbox"/> Herpes | <input type="checkbox"/> Psychiatric care | <input type="checkbox"/> Vaginal infections |
| <input type="checkbox"/> Breast lump | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Rheumatic fever | |
| <input type="checkbox"/> Severe sprains | <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Seizures | <input type="checkbox"/> Other | |

ALLERGIES? *Check appropriate box below. If yes, please list all known allergies to medications or substances*

- No known allergies Yes, I have the following allergies:

MEDICATIONS *List all medications you are currently taking, including the dose and frequency*

HEALTH HABITS *Check appropriate boxes below and describe*

- | | |
|------------|--|
| Caffeine | <input type="checkbox"/> None <input type="checkbox"/> _____ drinks per _____ |
| Tobacco | <input type="checkbox"/> None <input type="checkbox"/> _____ cigarettes per day <input type="checkbox"/> Quit smoking around _____ |
| Alcohol | <input type="checkbox"/> None <input type="checkbox"/> _____ drinks per _____ |
| Drugs | <input type="checkbox"/> None <input type="checkbox"/> |
| Diet | Describe: _____ |
| Exercise | Describe: _____ |
| Seat belts | <input type="checkbox"/> Always <input type="checkbox"/> Never <input type="checkbox"/> Sometimes |

(Continued on back)

SURGICAL HISTORY			PREGNANCY HISTORY		
Year	Hospital / City / State	Type of surgery / complications, if any	# pregnancies _____ ; # living children _____		
			# deliveries: C-sections _____ ; vaginal _____		
			Birth year	M or F	Complications, if any

OTHER HOSPITALIZATIONS, SERIOUS ILLNESSES, INJURIES

Year	Hospital / City / State	Reason for hospitalization, nature of illness or injury

Have you ever had a blood transfusion? No Yes Date(s): _____

FAMILY HISTORY

Fill in information about your family below:

Check if a blood relative has had any of the following:

Relation	Age, if living	Age at death	Medical conditions / cause of death	Disease	Relationship to you
Father				<input type="checkbox"/> Arthritis	
Mother				<input type="checkbox"/> Asthma	
Brothers				<input type="checkbox"/> Cancer	
				<input type="checkbox"/> Diabetes	
				<input type="checkbox"/> Gout	
				<input type="checkbox"/> Heart disease	
Sisters				<input type="checkbox"/> High blood pressure	
				<input type="checkbox"/> Kidney disease	
				<input type="checkbox"/> Stroke	
				<input type="checkbox"/> Other	

ADDITIONAL INFORMATION *What else do you think your doctor should know about your health?*

I certify that the information on this form is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature _____ Reviewed by _____ Date _____