The Desert Sports Medicine and Shoulder Clinic
New Patient Medical History

Name:		Date of Birth:		Today's Date:	
Referring Physician:			Physician #:		
Primary Care Physician:			PCP #:		

CHIEF COMPLAINT

Why are you here today?			
Which side is involved? ☐ Right ☐ Left ☐ Both			
What makes it better?			
What makes it worse?			
Your problem is the results of an "(Check all that apply)?"			
☐ Accident	☐ Car Accident	☐ Work Accident	☐ Other

MEDICATIONS INCLUDING ALL VITAMINS, MINERALS & HERBS

	Medication	Dose/Frequency	How Long Taking?	Side Effects?
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				

ALLERGIES

Are you allergic to any of the following? (Check all that apply)

☐ Aspirin	☐ Codeine	☐ Sulfa	☐ Penicillin	☐ Keflex	☐ Latex	☐ Steroid injections

Other allergies:

Serious side effects?

For Women: Are you taking birth control pills? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Week #:

VITALS

Age:	Height:	Weight:

Signature:		Date:	

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SURGERIES/HOSPITALIZATIONS

	Type of Surgery	Year	Complications
1			
2			
3			
4			
5			
6			
7			

Have you ever had general anesthesia?	☐ Yes ☐ No
Have any problems with anesthesia?	☐ Yes ☐ No

REVIEW OF SYSTEMS

Check or circle all of the following diseases or medical problems that you have had at any time.

☐ High / Low blood Pressure	☐ Shortness of Breath
☐ Anemia / Transfusions	☐ Epilepsy / Seizures / Fainting Spells
☐ Radiation Treatments	☐ Heart Attack / Heart Bypass Surgery
☐ Blood Clots / Pulmonary Embolus	☐ Pacemaker
☐ Hepatitis	☐ Heart Murmur / Congenital defect
☐ HIV / AIDS	☐ Mitral valve prolapse
☐ Hemophilia / Abnormal Bleeding	☐ Bladder Problems / Kidney Problems
☐ Rheumatoid Arthritis	☐ Bowel Problems
☐ Artificial bone or joints	☐ Diabetes
☐ Bone Infections	☐ Polio
☐ Eyes	☐ Low Back Pain / Sciatica
☐ Ears / Nose / Throat	☐ Drug / Alcohol Abuse
☐ Stomach / Digestion	☐ Psychiatric Problems
☐ thyroid	☐ Cancer
☐ Asthma / Trouble Breathing	☐ Liver Disease

Describe any additional medical information that you feel we need to know:

SOCIAL HISTORY

Occupation:		Employer:		
Work Status:	☐ Full-Time	☐ Part-Time		☐ Restricted
☐ Disabled	☐ Retired	☐ Work at Home		☐ Student
Marital Status:	☐ Single	☐ Married	☐ Divorced	☐ Separated	☐ Widowed
Children:	☐ No	☐ Yes	How Many:	Do you live alone:	☐ No ☐ Yes
Exercise?:	☐ Daily	☐ Weekly	☐ Rarely	☐Never	
What type of Exercise?					
Are you on a special diet?	☐ Yes	☐ No	Describe:		
History of substance abuse?	☐ Yes	☐ No	Describe:		
Smoke currently?	☐ Yes	☐ No	Packs per day for:	years:	
Quit smoking?	☐ This year	☐ >1 year	☐ >5 year	☐ >10 year	
Previously smoke	packs per day for	years.		
Drink alcohol?	☐ Daily	☐ 1-2 x per week	☐ Never	☐ How much?