

MSU SPORTS MEDICINE

**If your Primary Care Physician is an MSU Physician,
please complete the second page of this form and inform Staff.**

CURRENT AND PAST HISTORY (Please Print)

Date _____

PATIENT NAME _____ DOB _____ Age _____ Ht. _____ Wt. _____

PRIMARY CARE PHYSICIAN/REFERRING PHYSICIAN _____

CHIEF COMPLAINT Right/Left/Bilateral _____

How did this injury occur and when: _____

Have you had the following done (relating to your injury)?	Yes	No	If yes, where?
X-rays			
MRI/CT Scan/Bone Scan			

SOCIAL HISTORY

Occupation:	Hobbies/Sports:
Smoking History: Never Past Current	How many Packs per Day:
Alcohol Use : Yes No Amount:	Addicting Drugs: Yes No Type:
Marital Status: S M D W Separated	Number of Children:
Race: African American American Indian/Alaskan Native Asian Native Hawaiian / Pacific Islander White Other	Ethnicity: Hispanic/Latino Non-Hispanic/Latino

MEDICATION ALLERGIES

Have you had an allergic reaction to a Medication(s) or Latex? Yes No

Medication	Side effect	Medication	Side effect
1.		4.	
2.		5.	
3.		6.	

CURRENT MEDICATIONS (INCLUDE NON-PRESCRIPTIONS & HERBAL SUPPLEMENTS)

Medication	Dose	Medication	Dose
1.		5.	
2.		6.	
3.		7.	
4.		8.	

FAMILY HISTORY

Family Member	Living	Ages	ie. (Hypertension, Diabetes, Heart Disease, OA/RA or Cancers)
Father			
Mother			
Brother (s)			
Sister (s)			

PAST SURGICAL HISTORY

Surgery	Year	Surgery	Year
1.		4.	
2.		5.	
3.		6.	

Patient Name _____ DOB _____ MRN # _____

REVIEW OF SYSTEMS

Fracture History:				
		Currently		History of:
System Review	Circle all that apply	Yes	No	Comments
Musculoskeletal	Sprains, dislocations, arthritis, osteoporosis, weakness, back pain, joint pain, cramps, stiffness			
Neurologic	Seizures, stroke, balance changes, head injury, numbness/tingling, tremors			
Constitutional	Fevers, weight gain/loss, night sweats			
Eyes	Visual loss or change, trauma, glasses, contacts, cataracts			
Ears, Nose, Throat	Loss of hearing, trouble swallowing, nosebleeds, hoarseness, earache			
Respiratory	Shortness of breath, asthma, difficulty breathing, emphysema, bronchitis			
Cardiovascular	Heart attack, irregular heart beat, heart murmur, chest pain, high blood pressure			
Gastrointestinal	Ulcer, hepatitis, weight changes, bowel changes			
Genitourinary	Painful urination, difficulty urinating, blood in urine, renal disease/failure			
Hematologic	Blood clots, anemia, bleeding problems, hepatitis			
Endocrinology	Tolerance to cold/heat, thyroid disease, growth changes			
Psychological	Eating disorder, mood changes, sleep changes, domestic abuse, substance abuse, anxiety, depression			
Skin	Color changes, infections, masses, open sores, hair changes, rash, itching			
Immunologic/Allergic	Dermatitis, latex allergy, hives, rash			
Other Health Problems:	Cancers, infectious disease, HIV, autoimmune disease, etc.			
History of MRSA (methicillin-resistant staphylococcus aureus)				

Patient/Guardian Signature _____

Date _____

Physician Signature _____

Date _____