PRINCETON SPORTS & FAMILY MEDICINE

# Medical History
# New Patient and Physical Form

Name: _____ D.O.B. _____

Height: _____ Weight: _____ Occupation: _____

Pharmacy: _____Location: _____

Reason you are here today:

_____ New Patient to Meet New Primary Care Physician
Initial here Discuss medical history, chronic medical conditions, review medications and evaluate a new problem.

_____ Annual Physical with Primary Care Physician
Initial here *Evaluation of any new or chronic medical problems may require a co-pay, deductible or co-insurance.*

_____ New Patient to Meet New Sports Medicine Physician - Discuss Injury & History
Initial here *Evaluation of any general medical conditions will require an appointment with our Primary Care Physicians.*

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**ALLERGIES/INTOLERANCES (FOOD, MEDICATION AND ENVIRONMENTAL) ~ PLEASE LIST REACTION**

_____ _____

_____ _____

**PAST SURGERIES AND DATES**

| SURGERY | DATE | SURGERY | DATE |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**OB/GYN HISTORY:**

# Pregnancies _____ Live Births _____ Miscarriages _____ Abortions _____ C-Sections _____

List other medical personnel involved in care and the reason for their treatment:

_____ _____

_____ _____

_____ _____

| CHRONIC MEDICAL CONDITIONS | CURRENT MEDICATIONS (Name, dosage, frequency) |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |

(OVER)

**SOCIAL HISTORY**

MARTIAL STATUES: □ SINGLE □ MARRIED □ DIVORCED □ WIDOWED □ PARTNERSHIP

DO YOU WEAR GLASSES OR CONTACTS? □ NO □ YES IF YES, □ GLASSES □ CONTACTS □ BOTH

DO YOU DRINK ALCOHOL? □ NO □ YES HOW OFTEN? _____ # OF DRINKS? _____

DO YOU SMOKE? □ NO □ YES □ IN THE PAST # PER DAY_____ #YEARS_____ CIGARETTES? CIGARS?

HAVE YOU EVER USED ILLEGAL DRUGS? □ NO □ YES IF YES, DID YOU USE IV DRUGS? □ NO □ YES

ARE YOU SEXUALLY ACTIVE? □ NO □ YES IF YES, □ MEN □ WOMEN □ BOTH

HAVE YOU EVER RECEIVED A BLOOD TRANSFUSION OR BLOOD PRODUCTS? □ NO □ YES

WHEN _____ REASON: _____

**HABITS:**

DO YOU EXERCISE? □ NO □ YES HOW OFTEN? _____ TYPE OF EXERCISE? _____

DO YOU DRINK CAFFEINE? □ NO □ YES CUPS PER DAY_____ TYPE OF CAFFEINE_____

WHAT KIND OF DIET DO YOU FOLLOW? □ UNRESTRICTED □ LOW SALT □ LOW FAT □ VEGETARIAN □ VEGAN □ GLUTEN FREE

HOW ARE YOU SLEEPING? □ NO PROBLEM □ DIFFICULTY FALLING ASLEEP □ DIFFICULTY STAYING ASLEEP □ SNORING

□ DAYTIME DROWSINESS PLEASE EXPLAIN : _____

**FAMILY MEDICAL HISTORY:**

| | DECEASED OR LIVING | AGE(S) |
|---|---|---|
| Mother | | |
| Father | | |
| Brother (s) | | |
| Sister (s) | | |
| Spouse | | |
| Children | | |

**Has any blood relative had? (PLEASE CHECK AND GIVE RELATIONSHIP, USE N/A IF NOT APPLICABLE)**

STROKE _____ EPILEPSY _____ HEART ATTACK _____ NERVOUS BREAKDOWN _____

CANCER (TYPE) _____ DIABETES _____ STOMACH ULCER _____ MIGRAINES _____

HYPERTENSION_____ ASTHMA_____ KIDNEY DISEASE_____ ARTHRITIS (O/A OR R/A) _____

GLAUCOMA_____ BLEEDING DISORDER _____ MENTAL ILLNESS _____ THYROID DISEASE_____

PULMONARY DISEASE_____ NEUROLOGICAL DISORDER_____ OSTEOPOROSIS_____

**PREVENTATIVE CARE & IMMUNIZATION HISTORY - List date of your last test/screening/vaccination: (if known)**

| | |
|---|---|
| 1) Meningococcal Vaccine: | 10) Bone Density Test (DEXA): |
| 2) Shingles Vaccine: | 11) Pap Smear: |
| 3) Tetanus Vaccine: | 12) Dental Exam: |
| 4) Pneumonia Vaccine: | 13) Physical Exam: |
| 5) HPV Vaccine: | 14) Eye Exam: |
| 6) Flu Vaccine: | 15) Rectal/Prostate/Testicular Exam: |
| 7) Hepatitis A Vaccine: | 16) Endoscopy: |
| 8) Hepatitis B Vaccine: | 17) Colonoscopy: |
| 9) Tuberculosis (PPD) Screening: | 18) EKG: |