EDINA SPORTS HEALTH & WELLNESS, PA "YOUR PARTNERS IN OPTIMAL HEALTH."

Acct # _____ DOB:_____

Patient Name: _____

HISTORY FORM

If this is your first visit with us, or it has been a year since your last physical, or your medical condition has changed significantly since your last visit please provide the information requested below. We feel this will make your visit go more easily and allow us to provide the best possible care.

PAST MEDICAL HISTORY (include all surgeries and hospitalizations since birth)

Allergies

_____
_____
_____
_____

Medication (include meds not taken every day & herbals & vitamins)

_____
_____
_____
_____

_____
_____
_____
_____

Hospitalizations/Date

_____
_____
_____
_____

Surgeries/Date

_____
_____
_____
_____

Misc. (Medical Problems)

_____
_____
_____
_____

PERSONAL & FAMILY MEDICAL HISTORY

(INDICATE Y = YES, N = NO (FOR PERSONAL HISTORY), And for Family use M = MOTHER, F = FATHER, S = SIBLING, GP = GRANDPARENT)

	Y	N	Family
Allergies/Hay Fever			
Anemia			
Arthritis			
Asthma			
Bleeding Disorder			
Bowel Irregularity			
Bronchitis/Pneumonia			
Cancer (type_____)			
Chest Pain			
Depression/Mental illness			
Diabetes			
Dizziness/Fainting			
Gallbladder Disease			

	Y	N	Family
Gastric Ulcer			
GI Disorder			
Glaucoma			
Gout			
Headaches			
Heart Disease/MI			
Heart Murmur			
Hepatitis			
High Blood Pressure			
High Cholesterol			
Incontinence			
Irregular Heartbeat			
Kidney Disease			

	Y	N	Family
Lactose (milk) Intolerance			
Osteoporosis			
Poor Circulation			
Prostate Disease			
Rheumatic Fever/Scarlet Fever			
Seizure Disorder			
Sexual/Menstrual Dysfunction			
Shortness of Breath			
STD's/HIV			
Stroke/CVA			
Other_____			

Personal Risk Factors

	Y	N
Bike/Helmet Use (if bike use)		
Guns in Household/Safety		
Smoke/CO Alams		
Obesity		
Poor Dental Hygiene		
Poor Diet		
Prone to Falls/Frailty		
Seat Belt Use		
Sleep/Snoring		

	Y	N	
Stress			
Work Hazards			
Alcohol Use			qty _____per day _____per week
Caffeine Use			qty _____per day _____per week
Chemical Use/Drug Use			type _____
Family Planning/Contraception			type _____
Sexual Behavior/HIV Risk			type _____
Use of Tobacco/Smoking			qty _____per day _____per week

Family Status

Mother: Living _____ Deceased _____ (Date/Cause)

Father: Living _____ Deceased _____ (Date/Cause)

Siblings: # Living _____ # Deceased _____ (Date/Cause) Comments:_____

PLEASE SEE OTHER SIDE

SOCIAL HISTORY

Occupation:_____

Interest/Hobbies:_____

Single ☐ Married ☐ Divorced ☐ Other ☐ Level of Education: Elementary ☐ High School ☐ College ☐ Illiterate ☐

Number of Children: Living _____ Deceased _____

Number in Household: _____ Speaks English ☐ Speaks: _____

Disability? Yes ☐ Explain: _____ No ☐

Special Needs:_____

Sexually Active? Yes ☐ No ☐ Number of Sexual Partners: _____

PERSONAL ACTIVITIES

Do you exercise? No Yes How Often/How long: _____

What type of exercise do you do? _____

What is your diet (types of foods you eat, drink or avoid) _____

_____

OB-GYN (FEMALES ONLY)

of Pregnancies _____ # of Live Births _____ Full term / premature Miscarriges/Other _____

Menstral Cycle: Regular ☐ Irregular ☐ Flow: Average ☐ Heavy ☐ Light ☐

Age at 1st period: _____ Age at menopause: _____

Hysterectomy? No Yes IF yes when and by who: _____

Treated for STD's? No Yes Explain: _____

Abnormal Pap(s)? No Yes Explain: _____

Current birth control method: _____

Comments: _____

IMMUNIZATION STATUS

Tetanus Shot Date:_____ Pneumonia Vaccine Date: _____

ADVANCE DIRECTIVES

Do you have a Living Will or Health Care Power of Attorney? Yes ☐ No ☐

Has a copy been given to Edina Sports Health & Wellness? Yes ☐ No ☐

Signature of person initially completing this form: _____

Name/Title

FOR OFFICE USE ONLY

Reviewed/Updated/Initialed: Date: _____ Date: _____ Date: _____ Date: _____

Date: _____ Date: _____ Date: _____ Date: _____ Date: _____

Date: _____ Date: _____ Date: _____ Date: _____ Date: _____

Date: _____ Date: _____ Date: _____ Date: _____ Date: _____