SPORTS MEDICINE CLINIC OF NORTH TEXAS

Date: _____ **PATIENT MEDICAL HISTORY** File # _____

Please print, answer all questions and sign where indicated

Patient's Name: _____ Date of injury/or onset of problem: _____
Indicate body part(s) affected: _____
Please describe your injury or problem: _____

Was this an automobile accident? ☐ Yes ☐ No Were you injured on your job? ☐ Yes ☐ No

Is injury related to a school athletic function? ☐ Yes ☐ No Name of School: _____
Is injury related to a club team athletic function? ☐ Yes ☐ No Name of Club Team: _____

Sport: _____ Coach: _____ Trainer: _____

MEDICAL HISTORY

Height _____ ft _____ in Weight _____ lbs

Please check if you have had any of the following:

	Year	Explain details/Comments		Year	Explain details/Comments
☐ High Blood Pressure			☐ Cancer		
☐ Heart Attack/Chest Pain			☐ Lung Disease		
☐ Neurological Disease			☐ Kidney Disease		
☐ Gastrointestinal Disease			☐ Hepatitis		
☐ Diabetes			Do you smoke? ☐ Yes ☐ No		

PLEASE LIST ANY HOSPITALIZATIONS AND/OR SURGERIES

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

ARE YOU CURRENTLY TAKING ANY MEDICATION? ☐ Yes ☐ No

If yes, please list ALL medications: _____

ARE YOU ALLERGIC TO ANY MEDICATION? ☐ Yes ☐ No

If yes, please list medications and any reaction you had: _____

FAMILY MEDICAL HISTORY

Is there a family history of:

Diabetes	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Sudden Unexplained Death	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Reaction to Anesthesia	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Heart Attack	☐ Yes ☐ No	Cancer	☐ Yes ☐ No

DO YOU HAVE A LIVING WILL? ☐ Yes ☐ No If yes, and you are over age 65, please provide a copy.

AUTHORIZATION TO RELEASE MEDICAL RECORDS/ASSIGNMENT TO PHYSICIANS

I hereby authorize _____, M.D. to furnish information to Insurance carriers concerning my illness or injury and treatments. I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amounts not covered by Insurance. (A copy of this authorization shall be as valid as the original.)

Insured's Signature Date