



**OUCH SPORTS MEDICAL**

27450 Ynez Rd. Ste. 128

Temecula, CA 92591

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Hospitalizations / Surgeries:**

<u>Why</u>	<u>How old Were you</u>	<u>Name of Hospital</u>	<u>When</u>
1			
2			
3			

**Family History:** \_\_\_\_\_ **Father** \_\_\_\_\_ **Mother** \_\_\_\_\_

If alive, current age? \_\_\_\_\_

Any medical problems? \_\_\_\_\_

If deceased, age at death? \_\_\_\_\_

Cause of death? \_\_\_\_\_

Any family history of alcohol or drug use? \_\_\_\_\_

Any family history of cancer? What Kind? \_\_\_\_\_

At what age did cardiac problems start? \_\_\_\_\_

Ethnic background (optional) \_\_\_\_\_

**Medications:** List all prescription meds (birth control pills, heart med.): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Supplements:** (vitamins, garlic, glucosamine) \_\_\_\_\_

**Over the counter medications:** (Aspirin, Tylenol, Sudafed, cough syrup, etc)

\_\_\_\_\_  
\_\_\_\_\_

**Allergies to Medication or Environmental:** (Reaction (Hives, rash, shortness of breath,  
Diarrhea, stomach pains, nausea/vomiting)

\_\_\_\_\_  
\_\_\_\_\_

**Yes or No** \_\_\_\_\_ **Why?**

**Use of Acupuncture:** \_\_\_\_\_

**Use of Chiropractor:** \_\_\_\_\_

**Use of Herbalist:** \_\_\_\_\_

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**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Social History:**

Marital Status:    Single    Married    Separated    Widowed    Other \_\_\_\_\_

Children:        Number: \_\_\_\_\_        Age/Sex: \_\_\_\_\_

Siblings:        Number: \_\_\_\_\_        Age/Sex: \_\_\_\_\_

Occupation (or daily activity) \_\_\_\_\_

Are you on a special diet (low salt, high fiber, etc.) \_\_\_\_\_

How many fruits and vegetables did you eat yesterday? \_\_\_\_\_

Hours of exercise per week / type of exercise: \_\_\_\_\_

Hobbies / Interests: \_\_\_\_\_

Special Accomplishments: \_\_\_\_\_

**Review of Symptoms** (Please indicate if you are currently having problems in any of these areas)

General(Change in weight, energy level, etc). \_\_\_\_\_

Head, Ears, Eyes, Nose, Throat, Neck: \_\_\_\_\_

Lungs, Breathing (cough/shortness of breath) \_\_\_\_\_

Heart (pain, palpitations, angina) \_\_\_\_\_

Abdomen (diarrhea, pain, blood) \_\_\_\_\_

Urinary (pain, burning, change in size of stream) \_\_\_\_\_

Sexual concerns (pain, discharge, impotence) \_\_\_\_\_

Arms/Legs (arthritis, swelling, trauma) \_\_\_\_\_

Nervous/Mental (tremor, change in memory, depression/anxiety) \_\_\_\_\_

Skin concerns (suspicious mole, rash, acne) \_\_\_\_\_

Alcohol, drinks per week \_\_\_\_\_. Has anyone ever said they were concerned about your drinking? Y / N

Tobacco, type \_\_\_\_\_ packs per day \_\_\_\_\_ Number of years: \_\_\_\_\_

Recreational drugs (marijuana, cocaine, crystal meth, speed, etc. \_\_\_\_\_

How much / often \_\_\_\_\_

Please add anything else that you think might be important regarding your health:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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