East Suburban Sports Medicine Center
MEDICAL HISTORY QUESTIONNAIRE

NAME: _____ **DOB**: _____

ALLERGIES: _____

LIST OF MEDICATIONS: _____

_____

_____ **DATE OF**

INJURY AND HOW IT OCCURRED: _____

_____

_____

EMERGENCY CONTACT: (name)_____

(home phone #)_____**(cell #)**_____

Do you currently experience?

Have a pacemaker	Yes	No	Night pain	Yes	No
Chest pain	Yes	No	Numbness in genitals/anal area	Yes	No
Changes in bowel function	Yes	No	Pregnancy	Yes	No
Changes in bladder function	Yes	No	Vision problems	Yes	No
Dizziness/fainting	Yes	No	Hearing problems	Yes	No
Fever/chills	Yes	No	Speech problems	Yes	No
Headaches	Yes	No	Shortness of breath	Yes	No
Nausea/vomiting	Yes	No	Unexplained weakness	Yes	No
Night sweats	Yes	No	Unexplained weight change	Yes	No

THE ABOVE STATEMENTS ARE TRUE TO THE BEST OF MY KNOWLEDGE:

SIGNATURE _____ DATE: _____