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:

Office documents / no ltrhd / Medical history questionnaire short12/2017