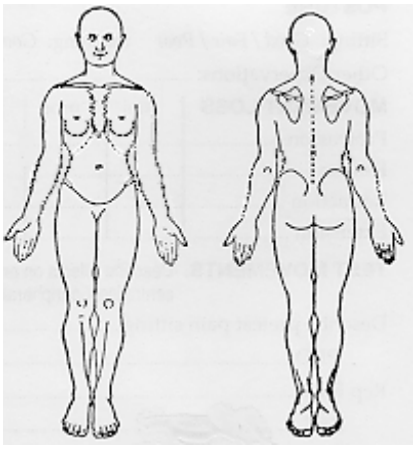
Rebecca A. Demorest, MD
Pediatric and Young Adult Sports Medicine
Confidential Medical History
To be filled out by Patient and /or Parent/Guardian

Name_____ Date_____ Age_____
Date of Birth_____ Parent/ Guardian_____
Name of person(s) filling out this form _____ Relationship to patient_____
School_____Grade in school_____
Sports Played _____
How would you describe your or your child's level of physical activity over the past six months?
_____ Inactive
_____ Light activity (Occasional play/walk at recess or after school, PE class)
_____ Daily activity (Regular PE class, play at recess or after school)
_____ Organized Sports, School or Community Team
_____ Travel Sports Team
_____ National/Pre-Olympic Level TrainingName of training facility_____

Primary Care Physician_____
Address_____
Phone/Fax_____
Referred by_____

Chief Complaint_____
Date of injury or onset of symptoms: _____
Describe the injury or problem: _____
_____
_____
_____



Where is your pain? Please mark the drawing on the left.

Rate Your Pain:
0 = No pain 10 = Extreme pain

1. Right now 0 1 2 3 4 5 6 7 8 9 10
2. At best 0 1 2 3 4 5 6 7 8 9 10
3. At worst 0 1 2 3 4 5 6 7 8 9 10

4. What makes the pain better?_____
5. What makes the pain worse?_____

Have you seen a physician for this problem? Y N
If yes, who did you see? _____
Have you had any imaging (Xray, MRI, CT) for this problem? Y N
Imaging Studies and Dates performed_____
_____
Have you had physical therapy for this problem? Y N
PT Place and dates_____

Your Medical History

Do you have any ongoing or past medical problems? (asthma, heart disease, etc)_____

_____

Do you have any current or past orthopedic problems? _____

_____

Have you ever been hospitalized? Y N If yes, why and when ?_____

Have you ever had surgery? Y N If yes, why and when?_____

Current medications (prescription and over the counter):

_____

_____

Are you allergic to any medication(s)? Y N If yes, list medication(s) and reaction(s)

_____

Are your immunizations up to date? Y N

Your Gynecological History (for females only)

Have you started to get your periods? Y N

Age you began menstruating:_____ When was your most recent menstrual period? _____

How many periods have you had during the last 12 months? (circle one)

10-12 7-9 5-6 1-6 none

Your Child's Birth History

Complications with Pregnancy_____

Complications with Delivery _____

□Full term □Pre-term How preterm? _____

Did your child gain all developmental milestones on time? Y N If no please explain:

_____

Your Family History

Does anyone in your family have any of the following problems? (please check all boxes that apply)

□ Heart disease	□High blood pressure	□High Cholesterol	□Sudden Death
□Arthritis	□Cancer	□Stroke	□Seizure
□Anemia	□Abnormal Bleeding	□Genetic Disorder	□Asthma
□Seasonal Allergies	□Osteoporosis	□Frequent Fractures	□Diabetes
□Depression/Anxiety	□Thyroid Problems	□Other:_____	

Your Current Symptoms or Problems

Please check any of the following that apply to you:

◊ Recent weight change
◊ Fatigue/weakness
◊ Fever, chills
◊ Skin rash/disease
◊ Vision problems/eye disease
◊ Nose/throat problem
◊ Hearing problems/ear disease
◊ Frequent headaches
◊ Fainting spells
◊ Seizures
◊ Problems with coordination
◊ Depression
◊ Thyroid problems
◊ Change in appetite or thirst
◊ Shortness of breath or wheezing
◊ Frequent cough
◊ Chest pain
◊ Heart murmur
◊ Frequent Fractures
◊ Irregular heart beat
◊ Heart disease
◊ Swollen legs or feet
◊ Stomach pain or heartburn
◊ Ulcers
◊ Hepatitis or gallbladder disease
◊ Change in bowel habits (also blood in stools)
◊ Blood disorder or blood transfusion
◊ Easy bleeding or bruisability
◊ Change in urinary habits (including pain, blood in urine, trouble stopping/starting your urine)
◊ Kidney disease or kidney stones
◊ Joint stiffness, pain or swelling
◊ Muscle weakness
◊ Difficulty in moving an arm or leg
◊ Other _____

_____ _____

Patient/Parent Guardian Signature **Physician Signature**