



Lendermon sports medicine

9950 Crooked Creek Dr. Collierville, TN 38017 901.850.5756 Fax 901.850.5911

HEALTH HISTORY

Date: Name: Age: Were you referred by a Physician? Yes No What is your current occupation? Who requested our services? Reason for seeking medical attention Date of injury or duration of symptoms Work related? Yes No Are you right or left handed? Right Left Both Have you had any diagnostic studies for this condition, such as MRI, Bone Scan, etc? Please list Have you seen anyone else regarding this condition? Yes No If yes, list names and dates

Are you allergic to: (check if you are) Latex Penicillin Cephalosporin Mycins Sulfa Tetanus Iodine Metal Dyes Aspirin Codeine Morphine Adhesive Tape Arthritis Medicine

Foods (please list): Others:

Please explain allergic reaction:

Do you currently use tobacco: Cigarettes Pipe Smokeless Amount per day: Quit when? Do you drink alcohol: Beer Liquor Wine Amount per day: or per week:

Ht. Wt. Blood Pressure: Pulse:

Table with 3 columns of medical conditions and 2 columns of Yes/No responses. Conditions include Asthma, Rheumatoid Arthritis, Osteoarthritis, Kidney Disease, Anemia, Alcoholism, Lupus, Migraines, Sickle Cell Disease, Bleeding Tendencies, Cancer, Colitis, Heart Disease, Diabetes, Stroke, Epilepsy, Goiter, Stomach Ulcers, High Blood Pressure, Lung Disease, Depression/Anxiety, Polio, Nervous System Disorder, Pelvic Radiation, Hepatitis, Tuberculosis, COPD, DVT (Blood Clot), Sleep Apnea, (Chronic Obstructive Pulmonary Disease)

Other Medical Conditions:

Has anyone in your family had: Cancer* Gout High Blood Pressure Heart Disease Diabetes Bleeding Problems Lung Disease DVT (Blood Clot)

* If yes, what type of Cancer:

Are there law suits pending on your orthopaedic condition?

Please list any orthopaedic surgeries and dates: Please list any other surgeries and dates:

Please list all current medications and dosages:

Table with 3 columns of symptoms/problems and 2 columns of Yes/No responses. Symptoms include Chest Pain, Irregular Heart Beat, Fainting Spells, Breathing Difficulties, Cough, Cough with Blood, Numbness or Tingling, Dizziness, Headaches or Migraines, Vision Changes, Fever or Chills, Unexpected Weight Loss, Abdominal Pain, Nausea or Vomiting, Diarrhea, Bloody or Black Tarry Stools, Loss of Control of Bowels, Difficulty Starting Urine, Pain or Burning on Urination, Blood in Urine, Loss of Control of Bladder

Patient Signature: Physician's Signature: Date:

(I have reviewed this information with the patient)