CJW SPORTS MEDICINE

Dr. Jennifer Hopp

Patient Health History Form

Name: _____ Age: _____ Referral Source: _____

Reason for today's visit: _____

_____

_____ Onset Date: _____

List any x-rays, MRI's, or other diagnostic studies you've had that are related to today's visit:

_____

PAST MEDICAL HISTORY: Have you had any of the following?

(Circle "Y"= Yes, "N"= No "F" = Family)

Arthritis	Y N F	High Blood Pressure	Y N F	Peptic Ulcer/GI Problem	Y N F
Asthma	Y N F	Heart Disease	Y N F	Sprain/Strain	Y N F
Bleeding Disorder	Y N F	Kidney Disease	Y N F	Sleep Disorder	Y N F
Cancer	Y N F	Neurologic Disorder	Y N F	Thyroid Disease	Y N F
Diabetes	Y N F	Osteoporosis	Y N F	Congenital Birth Defect	Y N F

List all operations: _____

Do you have any metal clips inside you? Yes / No If yes, location: _____

Have you ever broken any bones? Yes / No If yes, location: _____

List allergies (include food & medicine): _____

Do you Smoke? Yes / No If yes, how much? _____

Do you drink caffeine? Yes / No If yes, how much? _____

Do you drink alcoholic beverages? Yes / No If yes, how much? _____

Any diet/nutritional concern: _____

_____

What type of work do you do? _____

Primary sports and hobby interests: _____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor Or any member of his/her staff responsible for any errors that I may have made in completion of this form.

Signature: _____ **Date:** _____

Reviewed by: _____ **Date:** _____