SIMONIAN Sports Medicine CLINIC
A Medical Corporation
A MEMBER OF COMMUNITY FOUNDATION MEDICAL GROUP & A PART OF SANTÉ HEALTH FOUNDATION

# Current Problem and Medical History

| Patient's Name | Today's Date |
|---|---|
| | |

## SOCIAL HISTORY

| Patient's Age | Gender ☐ Male ☐ Female | Occupation | Sports/Exercises/Hobbies |
|---|---|---|---|
| | | | |

| Marital Status | Highest Level of Education |
|---|---|
| ☐ Single ☐ Married ☐ Widow ☐ Divorced ☐ Separated | ☐ High School ☐ College ☐ Graduate School |
| Do You Smoke? ☐ No ☐ Yes How Much Per Week? _____ | Drink Alcohol? ☐ No ☐ Yes How Much Per Week _____ |
| Have You Had Chemical Dependency? ☐ No ☐ Yes, when? | Any Intravenous Drug Use? ☐ No ☐ Yes, when? |

## HISTORY OF PRESENT INJURY OR PROBLEM

1 Briefly describe your bone or joint problem and for what you would like help:

_____

_____

2 Injury — Is your problem related to an injury? ☐ Yes ☐ No

Briefly describe how and where it occurred _____

_____

3 Location — Where is your condition/problem?

☐ Right Shoulder ☐ Right Knee ☐ Right Arm ☐ Right Leg
☐ Left Shoulder ☐ Left Knee ☐ Left Arm ☐ Left Leg
☐ Other _____

4 Quality — Are you experiencing?

☐ Pain ☐ Weakness ☐ Swelling ☐ Color Change
☐ Numbness ☐ Tingling

What type of pain do you have?

☐ Dull ☐ Sharp ☐ Tightness ☐ Radiating

5 Severity — How strong is your pain?

☐ Light ☐ Moderate ☐ Severe

How bothersome is the problem?

☐ Interferes with Daily Activity ☐ Keeps You Up at Night
☐ Stops you from attending Work, School or Sports

6 Duration — How long has your problem lasted? _____ Days _____ Weeks _____ Months _____ Years

7 Timing — How does your pain/problem occur? ☐ Gradual Onset ☐ Intermittent ☐ Continual

Has the problem changed recently? ☐ Yes ☐ No

Have you had similar problems in the past? ☐ Yes ☐ No

8 Context — When does the pain/problem occur? ☐ Moving ☐ Lifting ☐ During Sports ☐ Other

9 + Factor — What makes the problem better? _____

10 - Factor — What makes the problem worse? _____

11 Associated — Have you had any related problems? _____

12 **PREVIOUS TEST(S) OR EXAM(S):** Please list all previous tests performed for this problem

| TEST | DATE PERFORMED | TEST | DATE PERFORMED |
|---|---|---|---|
| ☐ MRI | _____ | ☐ Bone Scan | _____ |
| ☐ EMG | _____ | ☐ Arthrogram | _____ |
| ☐ X-ray | _____ | ☐ Myelogram | _____ |
| ☐ CAT Scan | _____ | ☐ Other | _____ |
| ☐ Seen Another Specialist | _____ | | |

13 **IS YOUR INJURY/PROBLEM WORK OR JOB RELATED?** ☐ **NO** ☐ **YES**, Please Complete Below

| |
|---|
| Who is your Job Related Primary Physician? |
| What are the specific job duties effected by your injury or problem? |

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# Medical History Continued

## PAST MEDICAL HISTORY

1 **ANY PAST SURGERIES OR HOSPITALIZATIONS?** ☐ **NO** ☐ **YES,** Please List Below

| Type of Surgery/Hospitalizations | Date | Surgeon/Physican | Was it Helpful? |
|---|---|---|---|
| 1 | | | ☐ Yes ☐ No |
| 2 | | | ☐ Yes ☐ No |
| 3 | | | ☐ Yes ☐ No |
| 4 | | | ☐ Yes ☐ No |

2 **MEDICATIONS THAT YOU TAKE**

List All Medications Taken for this Problem:

| | |
|---|---|
| 1 | 4 |
| 2 | 5 |
| 3 | 6 |

List All Other Prescription or Nonprescripton Medications

| | |
|---|---|
| 1 | 5 |
| 2 | 6 |
| 3 | 7 |
| 4 | 8 |

3

| **LIST ANY ALLERGIES** to Any Medications or Substances | Type of Reaction |
|---|---|
| | |

4 **BLOOD & INFECTION HISTORY**

Do you now or have you recently taken "blood thinning" medication"? (Coumadin, Aspirin) ☐ Yes ☐ No

Have you ever had any problems with previous surgeries with excessive bleeding, clots or infections? ☐ Yes ☐ No

## FAMILY MEDICAL HISTORY

Have you, your mother, father, or siblings ever had treatment for?

| | **Yourself?** (Please Circle) | | **Family Member?** (Please Circle) | |
|---|---|---|---|---|
| Asthma | Yes | No | Yes | No |
| Diabetes | Yes | No | Yes | No |
| Heart Problems | Yes | No | Yes | No |
| High Blood Pressure | Yes | No | Yes | No |
| Cancer | Yes | No | Yes | No |
| Liver Disease/Hepatitis | Yes | No | Yes | No |
| Anxiety or Depression | Yes | No | Yes | No |
| Sexually Transmitted Disease | Yes | No | Yes | No |
| Bone or Joint Problems | Yes | No | Yes | No |

| | **Yourself?** (Please Circle) | | **Family Member?** (Please Circle) | |
|---|---|---|---|---|
| Pneumonia | Yes | No | Yes | No |
| Seizures | Yes | No | Yes | No |
| Thryroid Gland Problem | Yes | No | Yes | No |
| Tuberculosis | Yes | No | Yes | No |
| Lung Disease | Yes | No | Yes | No |
| Digestive Disorders | Yes | No | Yes | No |
| Other Illnesses | | | | |
| _____ | Yes | No | Yes | No |
| _____ | Yes | No | Yes | No |

**Do you have any other concerns?**

| Patient's Signature<br>**X** | Todays Date |
|---|---|

| Peter T. Simonian, MD<br>**X** | Todays Date |
|---|---|