Beaver Sports Medicine (Dr. Wobig)

Name:_____**Date of Birth**____/____/____

Emergency Contact: Name_____ Phone_____

Sex: ☐ Male ☐ Female Height_____ Weight_____

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Other

Occupation:_____ Last Date Worked: ___/___/____

Education: Grade in school or highest grade attained_____ Religion(optional)_____

Preferred learning technique? ☐Visual (seeing) ☐Auditory (hearing) ☐Kinesthetic (doing)

Habits:

Tobacco(check all that apply) ☐Cigarettes ☐Cigar ☐Chew ☐Marijuana
Daily amount:_____ How long:_____ Year Quit:_____

Alcohol (check all that apply) ☐Hard Liquor ☐Wine ☐Beer
Daily amount:_____How long:_____ Year Quit:_____

Caffeine (check all that apply) ☐Coffee ☐Tea ☐Pop
Daily amount_____How long:_____Year Quit:_____

Recreational Drugs_____

Family History (Parents and Siblings) Please check all that apply:
Please check all that apply and circle appropriate relatives(s): M = Mother, F = Father, B= Brother, S=Sister

☐ Heart Attack	M	F	B	S	☐ Asthma	M	F	B	S	☐ Seizure	M F B S
☐ Bleeding Disorders	M	F	B	S	☐ Gout	M	F	B	S	☐ Arthritis	M F B S
☐ Kidney Disease	M	F	B	S	☐ Psychiatric Disorders	M	F	B	S	☐ Diabetes	M F B S
☐ Birth Defects	M	F	B	S	☐ Cancer	M	F	B	S	☐ Stroke	M F B S
☐ Anesthesia Reaction	M	F	B	S	☐ High Blood Pressure	M	F	B	S		

Other Significant Family Problems:_____

Common Procedures (Please list dates):

☐Angioplasty_____ ☐Hernia Repair_____ ☐C-Section_____

☐Coronary Bypass_____ ☐Tonsillectomy_____ ☐Prostate Surgery_____

☐Hysterectomy_____ ☐Sinus Surgery_____ ☐Breast Biopsy_____

☐Gall Bladder Removal_____ ☐Appendectomy

Other Procedures:

Date	Procedure	Complications

Review of Systems:

Please check any conditions you currently have or have had in the past

General: ☐ No Problems ☐ Recent Weight Gain/Loss ☐ Fibromyalgia ☐ Appetite Change ☐ Cancer (Describe):_____ Other:_____	Gynecological: ☐ No Problems ☐ Abnormal Bleeding ☐ Fibroids ☐ Ovarian Cyst ☐ Post Menopause (date):_____ Other:_____
Eyes: ☐ No Problems ☐ Corrective Lenses ☐ Cataracts ☐ Foreign Body in Eye ☐ Glaucoma ☐ Blurred Vision Other:_____	Psychiatric: ☐ No Problems ☐ Bipolar Disease ☐ Depression ☐ A.D.D./A.D.H.D. ☐ Schizophrenia Other:_____
Head & Neck: ☐ No Problems ☐ Sinus Congestion ☐ Neck Pain ☐ TMJ Problems ☐ Hoarseness ☐ Swallowing Difficulty ☐ Bleeding Gums ☐ Sore Tongue/Gums ☐ Dentures ☐ Nasal Injury ☐ Hearing Aids ☐ Headaches Other:_____	Gastrointestinal: ☐ No Problems ☐ Abdominal Pain ☐ Ulcers ☐ Bloody Stools ☐ Heartburn ☐ Gallstones ☐ Hepatitis ☐ Bowel Incontinence ☐ Vomiting ☐ Constipation Other:_____
Pulmonary (Lungs): ☐ No Problems ☐ Shortness of Breath ☐ Pneumonia ☐ Sputum Production ☐ Coughing ☐ Coughing Blood ☐ Asthma ☐ Tuberculosis ☐ Wheezing ☐ Emphysema ☐ Sleep Apnea ☐ Oxygen Use ☐ CPAP/BiPAP Other:_____	Genitourinary: ☐ No Problems ☐ Urinary Incontinence ☐ Bloody Urine ☐ Urinary Tract Infections ☐ Hernia ☐ Frequency of Urination ☐ Bladder Prolapsed ☐ Prostate Problems Other:_____
Cardiac (Heart): ☐ No Problems ☐ High Blood Pressure ☐ Chest Pain ☐ Irregular Heartbeat ☐ Palpitations ☐ Swelling of Hands/Feet ☐ Murmur ☐ Heart Attack ☐ Pacemaker ☐ Defibrillator Other:_____	Musculoskeletal: ☐ No Problems ☐ Joint Stiffness/Pain ☐ Weakness ☐ Limitation of Motion ☐ Back Pain ☐ Osteoporosis ☐ Arthritis ☐ Broken Bones ☐ Muscle Spasm Other:_____
Endocrine ☐ No Problems ☐ Thyroid Disorder ☐ Excessive Thirst ☐ Diabetes ☐ Insulin Pump Other:_____	Hematologic/Lymph: ☐ No Problems ☐ Blood transfusion ☐ Blood Clots ☐ Bleeding Problems ☐ Enlarged Nodes ☐ Sickle Cell Disease ☐ Leukemia Other:_____
Neurological: ☐ No Problems ☐ Numbness/Tingling ☐ Seizures ☐ Parkinson's Disease ☐ Dementia ☐ Dizziness ☐ Strokes ☐ Tremors Other:_____	Skin: ☐ No Problems ☐ Change in Mole/Wart ☐ Psoriasis ☐ Lesions ☐ Eczema ☐ Itching ☐ Rash ☐ Masses Other:_____

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Allergies and reactions (Please check all that apply and list others):

☐ **No Known Allergies**

Substance	**Reaction**	**Substance**	**Reaction**
☐ Penicillin		☐ Morphine	
☐ Amoxicillin		☐ Demerol	
☐ Sulfa		☐ Dilaudid	
☐ Iodine		☐ Percocet	
☐ Tape		☐ Vicodin	
☐ Latex		☐ Codeine	
		☐ Aspirin	

Medication List

Please list all prescription, non-prescription, vitamin, mineral and herbal preparations

Medication	**Dose**	**Frequency**	**Verified**

Patient Signature:_____**Date:**_____/_____/_____
Reviewed:_____**Reviewed:**_____**Reviewed:**_____
Reviewer Comments:_____
_____