Sports Extra • 67 Walnut Ave., Suite 202 • Clark, NJ 07066
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# Patient Information Form

First Name: _____ Last Name: _____ M I _____

D.O.B: ___/____/_____ Sex: _____ Marital Status: __M __S __D __W

Date of Last Tetanus Shot _____

Occupation: _____ Hobby(s): _____

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*Please check the appropriate box and comment on all YES answers*

| **1. Have you ever:** | **Y** | **or N** | **Comments** |
|---|---|---|---|
| Been Hospitalized | ( ) | ( ) | _____ |
| Had Surgery | ( ) | ( ) | _____ |
| Broken a Bone | ( ) | ( ) | _____ |
| Had a Muscle Injury | ( ) | ( ) | _____ |
| Injured a Joint | ( ) | ( ) | _____ |

Knee ( ) Shoulder ( ) Ankle ( ) Elbow ( ) Wrist ( ) Other ( )

| **2. Has anyone in your immediate family ever had:** | **Y** | **or N** | **Comments** |
|---|---|---|---|
| Diabetes | ( ) | ( ) | _____ |
| Sudden Death (age <50) | ( ) | ( ) | _____ |
| High Blood Pressure | ( ) | ( ) | _____ |
| Asthma | ( ) | ( ) | _____ |
| High Cholesterol | ( ) | ( ) | _____ |

| **3. Have you ever had or currently have:** | **Y** | **or N** | **Comments** |
|---|---|---|---|
| Chest pain when or after you exercise | ( ) | ( ) | _____ |
| Dizziness with or after you exercise | ( ) | ( ) | _____ |
| High Blood Pressure | ( ) | ( ) | _____ |
| Racing of the heart / irregular rhythm | ( ) | ( ) | _____ |
| Wheezing cough with exercise | ( ) | ( ) | _____ |
| Weakness, fatigue, or anemia | ( ) | ( ) | _____ |
| Hearing loss / perforated ear drum | ( ) | ( ) | _____ |
| Headaches or migraines | ( ) | ( ) | _____ |
| Dental plate or orthodontic work | ( ) | ( ) | _____ |
| Impaired vision | ( ) | ( ) | _____ |
| Wear glasses / contacts | ( ) | ( ) | _____ |
| Hernia | ( ) | ( ) | _____ |
| Loss of any paired organ | ( ) | ( ) | _____ |
| Weight problem (under or over) | ( ) | ( ) | _____ |
| Menstrual Problems (if female) | ( ) | ( ) | _____ |

Age of 1st Period _____ Last Menstrual Period _____

| **4. Have you ever had:** | **Y** | **or** | **N** | **Comments** |
|---|---|---|---|---|
| Loss of consciousness | ( ) | | ( ) | _____ |
| Concussion | ( ) | | ( ) | _____ |
| Convulsions, seizures, or epilepsy | ( ) | | ( ) | _____ |
| Neck Injury | ( ) | | ( ) | _____ |
| “Stinger” “Burner” or “Pinched Nerve” | ( ) | | ( ) | _____ |
| Heat Exhaustion or Intolerance | ( ) | | ( ) | _____ |
| Heart Attack | ( ) | | ( ) | _____ |
| Stroke | ( ) | | ( ) | _____ |

| **5. Have you in the past or do you currently use:** | **Y** | **or** | **N** | **Comments** |
|---|---|---|---|---|
| Cigarettes, Chewing Tobacco, or Snuff | ( ) | | ( ) | _____ |
| Marijuana | ( ) | | ( ) | _____ |
| Alcohol | ( ) | | ( ) | _____ |
| Recreational Drugs | ( ) | | ( ) | _____ |
| Steroids | ( ) | | ( ) | _____ |
| Ergogenic Aids | ( ) | | ( ) | _____ |
| Vitamins or Supplements | ( ) | | ( ) | _____ |
| Weight Loss Medications, Laxatives | ( ) | | ( ) | _____ |
| Self Induced Vomiting | ( ) | | ( ) | _____ |
| Thyroid Medications | ( ) | | ( ) | _____ |
| Sedatives, Tranquilizers | ( ) | | ( ) | _____ |
| Sleeping Pills | ( ) | | ( ) | _____ |

| **6. Do you:** | **Y** | **or** | **N** | **Comments** |
|---|---|---|---|---|
| Exercise Adequately | ( ) | | ( ) | _____ |
| Average 7-8 Hours sleep per night | ( ) | | ( ) | _____ |
| Participate in Sports | ( ) | | ( ) | _____ |

**7. List any current mediations (include over-the-counter):**

_____
_____
_____
_____

**8. List any allergies:**

_____
_____
_____

**9. List any major medical problems not already mentioned**

_____
_____
_____