Seattle Sports &
Regenerative Medicine

PATIENT MEDICAL HISTORY

Patient Name_____
last first middle initial

Date of Birth____/____/____ Gender ☐Male ☐Female Age_____ Height_____ Weight_____

Occupation_____ Retired? ☐No ☐Yes

Primary Care Physician _____ ☐None Referred by: _____

Is this a work related injury? ☐No ☐Yes Right or left handed: _____

MEDICATIONS (Please list ALL medications including prescriptions, over-the-counter medications and blood thinning medications such as Coumadin, Plavix, aspirin, etc.) ☐None

Medication	Dose	How Often
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

ALLERGIES (Please list ALL allergies including contrast dyes, metal, latex, medication or other.) ☐None

Name	Specify Reaction (hives, rash, breathing difficulty, anaphylaxis)
1.	
2.	
3.	
4.	
5.	

PERSONAL MEDICAL HISTORY (Please check if YOU currently have or had the following diseases/conditions and circle any that apply.)

☐ Allergy to Antibiotics (Reaction:_____)
☐ Anemia/Bleeding Disorder
☐ Anesthesia Difficulties/ Malignant Hyperthermia
☐ Antibiotic Resistant Infection/MRSA
☐ Arthritis
☐ Asthma/COPD/Emphysema/ Breathing Problems
☐ Cancer (Type:_____)
☐ Diabetes
☐ DVT/Pulmonary Embolism/Blood Clots
☐ Epilepsy/Seizures/Convulsions
☐ Glaucoma
☐ Gout
☐ Heart Problems/Heart Attack/ Irregular Heartbeat/Stents
☐ High Blood Pressure
☐ HIV / HEP A/B/C
☐ Kidney Disease
☐ Liver Diseases
☐ Metal Allergy
☐ Muscular Dystrophy
☐ None
☐ Osteoporosis/Osteopenia
☐ Other (List: _____)
☐ Sleep Apnea
☐ Steroid Use
☐ Stroke/TIA
☐ Thyroid Disorder
☐ Tuberculosis
☐ Weakness

PATIENT MEDICAL HISTORY

PREVIOUS SURGERIES (Please list ALL previous surgeries and date.) ☐ None

Procedure / Date	Procedure / Date
1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

MEDICAL FAMILY HISTORY (Please check if anyone in your FAMILY has or had the following diseases/conditions and circle the applicable condition.)

☐ Glaucoma
☐ Epilepsy/Seizures/Convulsions
☐ High Blood Pressure
☐ Heart Problems/Heart Attack/Irregular Heartbeat/Stroke
☐ DVT/Pulmonary Embolism/Blood Clots
☐ Anemia/Bleeding Disorder
☐ Asthma/Breathing Problems/Emphysema
☐ Diabetes
☐ Thyroid Disorder
☐ Liver Diseases/Hepatitis (Type:_____)
☐ Kidney Problems
☐ Arthritis
☐ Gout
☐ Osteoporosis/Osteopenia
☐ Cancer (Type:_____)
☐ Metal Allergy
☐ Other (List:_____)
☐ Anesthesia
☐ None

SOCIAL HISTORY

Do you use tobacco? ☐ No ☐ Yes Packs Per Day:_____ If Quit when:_____

Do you drink alcohol? ☐ No ☐ Yes Type:_____ How Much/Often:_____

Are you pregnant? ☐ No ☐ Yes ☐ Possibly

Current or history of drug use? ☐ No ☐ Yes Type:_____ (including marijuana)

How many children do you have?_____ Number living with you?_____

REVIEW OF SYSTEMS (Please check if YOU are experiencing any of the following symptoms and circle any that apply.)

☐ Fever/Weight Loss or Gain/Chills/Fatigue
☐ Sore Throat/Difficulty Swallowing/Nose Bleeds/Ear or Hearing Problems/Headache/Migraines
☐ Excessive Thirst or Appetite/Excessive Urination/Heat or Cold Intolerable
☐ Visual Difficulty/Redness/Watery Eyes
☐ Chest Pain/Palpitations/Fainting/Murmurs
☐ Cough/Sputum Production/Snoring/Short of Breath/Wheezing
☐ Blood in Stool/Loss of Bowel Control/Nausea/Vomiting/Ulcers
☐ Bladder/Urological Problems/Painful Urination/Prostate Problems
☐ Bleeding Problems/Easy Bruising
☐ Joint Swelling/Stiffness/Redness/Heat/Muscle Pain/Swelling
☐ Depression/Nervousness/Anxiety/Hallucinations
☐ Skin Disorders/Rash/Poor Healing/Redness

The above information is true and correct to the best of my knowledge.

Patient Signature_____ Date _____

M.D. Review_____ Date _____