GRANGER MEDICAL CLINIC | *Alta View Sports Medicine*

Patient Information

Patient Name:_____ Date: _____

Primary Care Provider:_____ Phone: _____

Are you: ☐ Right-Handed ☐ Left-Handed Sex: _____ Age:_____ DOB: _____

History of Current Problem

Chief Complaint - What is the reason for today's visit? Please Describe.

_____

_____

_____

If Injured - Describe briefly how you were injured. Date of Injury: _____ , at work? ☐

_____

_____

_____

If Not Injured - Approximately when did your symptoms first appear?

_____

Health Habits - Check which substances you use and describe how much you use.

☐ Caffeine: How much_____ Yrs. _____

☐ Alcohol: How much_____ Yrs. _____

☐ Marijuana: How much _____ Yrs. _____

Occupational

Your Occupation: _____

☐ Drugs: How much_____ Yrs. _____

☐ Tobacco: How much _____ Yrs. _____

☐ Vitamins or Supplements: How much _____ Yrs. _____

Medications ☐ **None**

List prescription and non-prescription medications you are currently taking.

Medication _____ Dose per pill _____ Frequency _____

Medication _____ Dose per pill _____ Frequency _____

Medication _____ Dose per pill _____ Frequency _____

Medication _____ Dose per pill _____ Frequency _____

Allergies ☐ **None**

List any allergies and your reaction to medicine and/or other substances.

_____ _____

_____ _____

_____ _____

OVER

Medical History - All Information is Strictly Confidential

Please check any of the following that apply and describe at the bottom.

- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding disorders
- ☐ Blood Clots
- ☐ Cancer
- ☐ Change in moles
- ☐ Chest pain
- ☐ Diabetes ☐Type 1 ☐Type 2
- ☐ Emphysema
- ☐ Pulmonary Embolism
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ High Cholesterol
- ☐ High/Low Blood Pressure
- ☐ HIV Positive
- ☐ Hives
- ☐ Hospice
- ☐ Irregular/rapid heartbeat
- ☐ Itching/rash
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Migraine Headaches
- ☐ Multiple Sclerosis
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate problem
- ☐ Rheumatic Fever
- ☐ Scars
- ☐ Sore that won't heal
- ☐ Stomach Acid Reflux
- ☐ Stroke
- ☐ Thyroid problems
- ☐ Ulcers
- ☐ Varicose Veins
- ☐ Other: _____

Please explain any items that are marked unless self explanatory: _____

Surgical History ☐ **None**

Procedure	Year	Facility

Descibe any adverse reactions to past surgeries: _____

Signatures

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

Patient Signature: _____ Date: _____
(or parent/legal guardian signature if patient is a minor)

Reviewed By: _____ Date: _____

FOR OFFICE USE ONLY; PATIENT PLEASE LEAVE BLANK

Weight: _____ Height: _____ Blood Pressure: _____ Pulse: _____

Temperature: _____