REVIEW OF SYSTEMS

Circle any problems, illnesses or injuries that you have had

General: malaise, fever, night sweats, chills, weight gain, weight loss

Eyes: loss of vision, double vision, cataracts

Ears: hearing loss, ringing in your ears, dizziness

Nose: sinus infections, frequent bloody nose

Throat: frequent sore throat, strictures, hoarseness

Heart: chest pain, irregular heart beat, heart attacks, swelling of leg

Lung: difficulty in breathing, shortness of breath, pneumonia, bronchitis, asthma, coughing up blood, tuberculosis

Gastrointestinal: heartburn, stomach pain, blood in bowel movements, vomiting blood, ulcers, inability to control bowel movements

Genitourinary: blood in the urine, burning when urinating, sexually transmitted diseases, discharge, inability to control urination

Gynecologic: female problems, uterus removed, ovaries removed, currently taking birth control pills or estrogen, heavy or irregular mense, pain on intercourse, pain during menstrual cycle

Back: ruptured disc, car accidents, chronic pain, fractures, strains

Neck: ruptured disc, car accidents, chronic pain, fractures, strains

Musculoskeletal: muscle or bone diseases, broken bones, dislocations, osteoporosis, joint instability, chronic pain of an extremity

Neurologic: loss of sensation, abnormal sensation, tingling, numbness, loss of motor function, decreased strength

Skin: skin color changes, loss of pigmentation, abnormal moles, bleeding from moles, moles or dark spots increasing in size

Psychiatric: nervous breakdowns, seeing or hearing things that aren't there, depression, abnormal behavior, taking medication for a psychiatric condition

Patient Signature ________________________________ Date: ____________
MEDICAL HISTORY

Name: _____________________________ Age: ________

Family History:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Mother</th>
<th>Father</th>
<th>Mother's Parents</th>
<th>Father's Parents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart attack</td>
<td>☐ Age</td>
<td>☐ Age</td>
<td>☐ Age</td>
<td>☐ Age</td>
</tr>
<tr>
<td>Diabetes</td>
<td>☐</td>
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<tr>
<td>Lung Problems</td>
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<tr>
<td>Problems with anesthesia</td>
<td>☐</td>
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<tr>
<td>Arthritis</td>
<td>☐ Type</td>
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<tr>
<td>Cancer</td>
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</tr>
</tbody>
</table>

Social History: Do you

- Smoke: Yes ☐ No ☐ Packs Per day________ Years Smoked _________
- Drink: Yes ☐ No ☐ Drinks Per day________
- Abuse drugs: Yes ☐ No ☐ Type________________________________________
- Work (what type of work) ____________________________________________
- Are you married? Yes ☐ No ☐

Childhood Illnesses: (check ✓ if applicable)

- Measles
- Rubella
- Mumps
- Chicken Pox
- Other ______________________________

Adult Illnesses: (check ✓ if applicable)

- Diabetes
- Arhythmia
- Lung Disease
- AIDS
- Hepatitis
- Heart Attack
- Other ______________________________

Injuries: (List all head injuries, broken bones, back injuries, and date)

____________________________________________________________________

Prior Surgeries: (List type, date and any complications)

____________________________________________________________________
PRE-PARTICIPATION PHYSICAL EXAMINATION FORM

Today's Date: ____________

Name: ___________________________ Date of Birth: _______ / _______ / _______

SS#: _______ - _______ - _______ Right / Left handed (circle one) Age: ______

Home Address: ___________________________________________________________

(City) (State) (Zip)

School Address: __________________________________________________________

(City) (State) (Zip)

Cell Phone: (______) ___________________________ Home Phone: (_____) ___________________________

Emergency Contact: ___________________________ Relation: ___________________________ Emergency Phone: (_____) ___________________________

Do you have any of the following problems or a history of? (circle any that apply)

High Blood Pressure  Latex Allergy  Anemia  Asthma  Heart Problems  Mitral Valve Prolapse  Sleep Apnea
Seizures  Angina  Irregular Heart Beat  History of Stroke  Diabetes  Thyroid Condition  Mono  Shingles

1  Have you ever been hospitalized?  Yes  No  When/Why: ___________________________

2  Have you ever had surgery?  Yes  No  When/Why: ___________________________

3  Currently taking medications?  Yes  No  List: ___________________________

4  Do you have any allergies?  Yes  No  List: ___________________________

5  (pollen, drug, food, bee stings, etc)

6  Do you have asthma?  Yes  No  List medications: ___________________________

7  Do you have diabetes?  Yes  No  Shots / Pills / Diet control  List medications: ___________________________

8  Do you have epilepsy?  Yes  No  List medications: ___________________________

9  Have you ever had a concussion?  Yes  No  How many? ________  When: __________

10 Ever had a staph infection/MRSA?  Yes  No  When: __________________________

please PRINT clearly