ARIZONA SPORTS MEDICINE CENTER

Gary Waslewski, MD • Douglas Freedberg, MD • Charles Peterson, MD
Erik Dean, DO • Amit Sahasrabudhe, MD • Destin Hill, MD

Patient Name: ______________________ DOB ____________ Height ________ Weight ________

What are you seeing the doctor for today: ______________________ Affected side: Left Right

Date of injury or onset of problem: ______________________ Dominant Hand: Left Right

Work Related? ☐Yes ☐ No Auto Accident? ☐ Yes ☐ No Attorney Involved? ☐ Yes ☐ No

Have you had x-rays taken? ☐Yes ☐ No If yes, where? ______________________

Have you had an MRI? ☐Yes ☐ No If yes, where? ______________________

Primary Pharmacy: ______________________ Cross streets or address: ______________________

Phone Number: ______________________

Drug Allergies: ☐ Yes ☐ No Please list drug and reaction ______________________

Daily Medications: (please include pain meds, herbs, vitamins & OTC)

Name	Dosage/Strength	Times/day

Past Surgical History (list type and date)

____

____

____

Past Medical/Hospital History (Illness/Conditions):

____

____

____

Do you smoke? ☐ Yes ☐ No Packs per day: ____________

For how many years? ____________

Do you exercise? ☐ Yes ☐ No How Often? ____________

What type? (Running, biking, etc.) ____________

Do you drink alcohol? ☐ Yes ☐ No

If yes, average consumption a week? ____________

What is your occupation? ____________

Do you now or have you ever had:

Anemia	Yes	No
Diabetes	Yes	No
Cancer/Type	Yes	No
Kidney Trouble	Yes	No
Bladder Issues	Yes	No
High Blood Pressure	Yes	No
Heart Trouble	Yes	No
High Cholesterol	Yes	No
Asthma	Yes	No
Neurological Disorder/Seizures	Yes	No
Depression	Yes	No
Stroke	Yes	No
Thyroid Disorder	Yes	No
Ulcer/Stomach Problems	Yes	No
Hepatitis (Type)	Yes	No
Arthritis	Yes	No
Gout	Yes	No
Phlebitis/Blood Clots	Yes	No
AIDS/HIV	Yes	No
Substance Abuse	Yes	No
Fibromyalgia	Yes	No
Sleep Apnea	Yes	No

Family History:
Please list any major medical conditions & if they are deceased or alive:

Father: ____________

____

____

Mother: ____________

____

____

Siblings: ____________

____

____

Is there any possibility you could be pregnant? ☐ Yes ☐ No

Has any blood relative younger than 50 ever had unusual bleeding tendencies? ☐ Yes ☐ No

If yes, who and what is their age: ______________________

Have you or any blood relative, younger than 50, ever had a serious reaction to anesthesia? ☐ Yes ☐ No

If yes, who and what is their age? ______________________

The above information is, to the best of my knowledge, a true statement of my current condition.

Patient Signature: ______________________ Date: ____________