Medical History

Name: ______________________________

Have you RECENTLY noted any of the following (check all that apply)?

- ☐ Unexplained weight loss/gain
- ☐ Changes in bowel or bladder function
- ☐ Weakness/fatigue/loss of energy
- ☐ Changes to menstrual cycle
- ☐ Dizziness/lightheadedness
- ☐ Difficulty maintaining balance
- ☐ Unexplained falls
- ☐ Fever/chills/sweats
- ☐ Nausea/vomiting
- ☐ Change in appetite
- ☐ Difficulty swallowing
- ☐ Pain at night
- ☐ Infection (UTI, wound, etc.)
- ☐ Headaches/Migraines
- ☐ Shortness of breath
- ☐ A change in your health
- ☐ Numbness/Tingling
  where?

Have you ever been diagnosed or undergone treatment for any of the following (check all that apply)?

- ☐ Cancer
  type:_______________ when:_________
- ☐ Heart disease
- ☐ High Blood Pressure
- ☐ Angina / Chest Pain
- ☐ Stroke
- ☐ Peripheral artery disease or neuropathy
- ☐ Blood Clot
- ☐ Anemia
- ☐ Diabetes
- ☐ Osteoporosis / Osteopenia (circle one)
- ☐ Rheumatoid arthritis
- ☐ Osteoarthritis
- ☐ Thyroid problems
- ☐ Chemical dependency
- ☐ Eating Disorder
- ☐ Neurological Disorder (type: ________________________)
- ☐ Lung Condition/Disease (type: ________________________)
- ☐ Immunosuppression or compromised
- ☐ Other: ________________

Please list your current medications:

Are you currently taking blood thinners or anticoagulant medication? YES NO

Are you allergic to any of the following (check all that apply)?

- ☐ Sulfa Drugs
- ☐ Latex
- ☐ Metal
- ☐ Adhesive (i.e. bandaid, athletic tape, etc.)
- ☐ Hard work ☺
- ☐ Other: ____________________________________

In the past month have you been feeling down, depressed, or hopeless? YES NO

In the past month have you been bothered by having little interest or pleasure in doing things? YES NO

Are you pregnant? YES NO MAYBE ☺

Do you have a Pacemaker? YES NO

Date of your last physical exam: ______________

Height: ____________ Weight: ____________

What is your occupation? ______________________________

Do you live alone? YES NO

Do you have stairs in your home? YES NO

Do you smoke? YES NO

Office Use	BMI:	HR:	BP:	O2sat%:	Temp:

Please list any surgeries, major injuries, or other conditions requiring hospitalization (include date):

HIPAA NOTICE FOR PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.
The goal of HIPAA is to understand what is in your medical records and how your health information is used helps you as the patient ensure the accuracy, make more informed decisions when authorizing disclosure to others and better understand who, what, where and why others may access your health your health information. We at Alpine Sports Medicine are required to maintain the privacy of your health information and notify you that we have complied with the legal duties and privacy practices with respect to your information. If our information practices change, we will notify you of any changes.

Signature: ____ Date: ____________________