Midtown Sports Medicine
Eric S. Furie, M. D.

Patient Medical History

Today's Date: ____/____/______

Patient Name: ______________ FIRST ______________ MIDDLE ______________ LAST Sex: ☐ Male ☐ Female

Age: ______ Date of Birth: ____/____/______ Marital Status: ☐ Married ☐ Widowed ☐ Never Married ☐ Divorced/ Separated

Are you employed? ☐ Yes ☐ No **If yes**, what type of work: ______________

Emergency Contact Name: ______________ Cell or Day Phone #: ______________

Relationship: ______________

Referred by: ______________ **What is your main problem today?** ______________

Date of Onset (symptoms): ______________

Have you been treated somewhere else for this problem? ☐ Yes ☐ No **If yes**, where? ______________

Have you had x-rays taken for this problem? ☐ Yes ☐ No **If yes**, date taken ____/____/______

If yes, where were the x-rays taken: ______________

Have you been hospitalized for this problem? ☐ Yes ☐ No **If yes**, where: ______________

IF YOUR PROBLEM TODAY IS A RESULT OF AN INJURY, PLEASE COMPLETE THE FOLLOWING:

Date of Injury: ____/____/______ Time of Injury: ______ am/pm Work Injury? ☐ Yes ☐ No

How did this injury happen? ______________

Past Medical History: Please answer each of the questions below about your past health.

Have you ever had any serious illnesses? ☐ **Yes** ☐ **No** **If Yes,** please list them below and the year they happen.

1)______ 3)______

2)______ 4)______

Have you ever had any operations? ☐ **Yes** ☐ **No** **If Yes,** please list them below and the year they happen.

1)______ 3)______

2)______ 4)______

Family Medical History: Please check **Yes** or **No** below for each of the questions about **your family's health.**

Heart Disease	☐ Yes ☐ No	Sugar Diabetes	☐ Yes ☐ No	Tumor or Cancer	☐ Yes ☐ No
High Blood Pressure	☐ Yes ☐ No	Asthma	☐ Yes ☐ No	Other: ______	
Strokes	☐ Yes ☐ No	Free Bleeding	☐ Yes ☐ No		

Current Medical History: Please check **Yes** or **No** below for each of the questions about **your current health.**

Heart Disease	☐ Yes ☐ No	Sugar Diabetes	☐ Yes ☐ No	Bowel Problems	☐ Yes ☐ No
High Blood Pressure	☐ Yes ☐ No	Gland Disorders	☐ Yes ☐ No	Kidney Problems	☐ Yes ☐ No
Lung Problems	☐ Yes ☐ No	Stomach Problems	☐ Yes ☐ No	Bladder Problems	☐ Yes ☐ No
Bone Problems	☐ Yes ☐ No	Free Bleeding	☐ Yes ☐ No	Tumor or Cancer	☐ Yes ☐ No
Nerve Problems	☐ Yes ☐ No	Recent Weight Loss	☐ Yes ☐ No	Stomach Ulcer	☐ Yes ☐ No
Joint Problems	☐ Yes ☐ No	Recent Weight Gain	☐ Yes ☐ No	Yellow Jaundice	☐ Yes ☐ No
HIV or Known Risk	☐ Yes ☐ No	Drug Use	☐ Yes ☐ No	Alcohol Use	☐ Yes ☐ No
Current Smoker	☐ Yes ☐ No	**If Yes,** how many packs per day? ______		Other Problems	☐ Yes ☐ No

Please list any other health problems: ______________

Current Medications: Please list below, any medications you are currently taking. Please include any non-prescription medicines you take every day.

1) ☐ NONE 4)______

2)______ 5)______

3)______ 6)______

Medication Allergies: Do you have any allergies to medications? ☐ **Yes** ☐ **No** **If Yes,** please list those medications below:

1)______ 3)______

2)______ 4)______

Other Allergies: Are you allergic to latex products? ☐ **Yes** ☐ **No**

Do you have any other allergies? ☐ **Yes** ☐ **No** **If Yes,** please describe the allergies below:

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