Dignity Health.
Saint Francis Memorial Hospital

900 Hyde Street • San Francisco, CA 94109
(415) 353-6000

Name:

D.O.B.:

PATIENT HISTORY AND QUESTIONNAIRE

Please complete this form. The information will help your doctor, therapist and/or Dancemedicine specialist in the treatment of your problem. Today's Date:_____ Age: _____

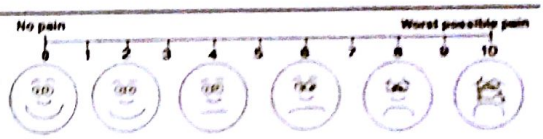
Please describe the location of your pain/injury: _____

_____

Date of Injury?_____

How were you injured?_____

Your pain level from this injury is: _____



Height_____ Weight_____ Name and phone of treating doctors _____

Date of last physical exam_____

What kinds of sports or dance activities were you involved in prior to your injury (list up to 4):

1. _____ 3. _____
2. _____ 4. _____

What are your goals for your main sports or activity? _____

_____

Who referred you to the Center for Sports Medicine? How did you hear about us?

_____

List any drug allergies that you have (prescription or over-the-counter medications):

_____

List any medications that your are taking on a regular basis and how often (prescription, over-the-counter, herbal, nutritional supplements) _____

_____

_____

_____

_____

List any past Hospitalizations or Surgeries (Please list dates):

_____

_____

Do you follow any special diet? (e.g. vegetarian, high protein, etc.?)

_____

If this was the result of a motor vehicle accident or workers comp injury, please list the following:

Time of injury:_____am/pm Location (where it happened): _____

Circumstances of Injury: _____

If this is a workers' compensation injury, please complete:

Are you able to perform your regular duties? ☐ Yes ☐ No

If no, please explain _____

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PATIENT HISTORY AND QUESTIONNAIRE

Social History

Marital status _____ Alcohol Use _____ Tobacco Use _____

History of Past/Current Illnesses

Circle if you have any of the following and please give details:

Cancer
Diabetes
Heart Disease
Hepatitis
Hypertension
Stroke
Sexually transmitted disease
Other illness or trauma

Family History

Circle and give details if any blood relative has had:

Arthritis
Bleeding disorder
Diabetes
Cancer
Heart Disease
Hypertension

Please give details of state of health of relative. If deceased, give age and cause

Father _____ Siblings _____
Mother _____ Son/Daughter _____

Review of Systems

Circle the following apply and give details/medications

Skin
Skin disease
Rash or Hives
Frequent infections

Head, Neck, Eyes, Ears, Nose, Throat
Eye disease
Glasses
Headaches
Glaucoma
Itching eyes/nose
Runny nose
Sinus problems
Sore throat
Hearing problems
Thyroid problems
Neck stiffness

Respiratory
Asthma/Breathing problems
Cough

Cardiovascular
Chest pains
Shortness of breath
Heart trouble
Swollen hands or lower extremities
Pain with walking relieved by rest

Gastrointestinal
Ulcer
Vomiting
Abnormal or painful bowel movements
Frequent diarrhea
Indigestion

Genitourinary
Frequent urination
Painful urination
Kidney trouble
Blood in urine
Are you pregnant?_____
Date of last menstrual period_____

Musculoskeletal
Leg cramps
Foot pain or burning
Joint pain

Hematologic
Slow wound healing
Anemia
Blood disease

Endocrine
Hormone therapy
Change in hair growth

Neuro-psychiatric
Psychological problems
Neurologic disease

Other: _____

Patient Signature:_____ Date: _____ Time: _____

E-mail Address (Optional): _____

☐ Interpreter utilized. Name of interpreter / service: _____