TRSM Tennessee Regenerative SPORTS MEDICINE

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Health Information Questionnaire

Name:____ DOB:________________

Primary Care Physician:__________________________________

Preferred Pharmacy:_______________________________ Telephone Number:_____________

Current Medications:	Prescribed by:

Please check any symptoms below that you are currently experiencing:

Musculoskeletal:
____ Joint pain
____ Muscle pain
____ Joint swelling
____ Joint stiffness
____ Limb pain/swelling
____ Muscle cramps/weakness

Neurological:
____ Limb weakness
____ Difficulty walking
____ Numbness
____ Tremor
____ Radiating pain

Past Medical History:

Check all conditions that apply:

Anemia		Arthritis		Blood Disease	
Cancer		Cholesterol		Diabetes	
GI Disease		Genital/Urinary Disease		Heart Disease	
High Blood Pressure		Liver Disease		Lung disease/Asthma	
Phlebitis		Psychological		Seizures	
Stroke		Thyroid Disease		Weight	

Past Surgeries:____

Allergies:____

Social History:
Do you use tobacco products? Yes ☐ No ☐
Do you drink more than 2 alcoholic beverages per day? Yes ☐ No ☐

Marital Status: ____Married ____Single ____Divorced ____Widowed

What is the reason for your visit today?____