Boston Sports Medicine

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MEDICAL QUESTIONNAIRE

Patient Name: _____ **Date:** _____

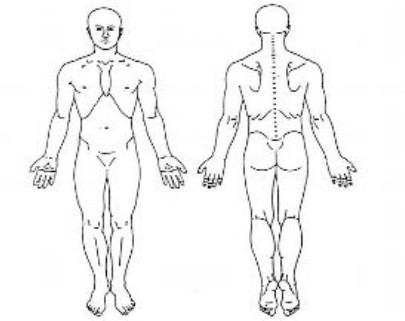
CURRENT COMPLAINT

Date of Injury or when you first experienced your symptoms: _____

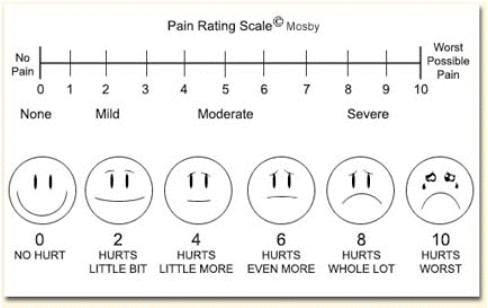
How did your problem start? _____

What makes your problem worse? _____ better? _____

Where is your pain located?
(please indicate with an "X" on the body chart below)



Please circle the ***lowest and highest*** your pain has been in the last 2 weeks. (*see chart below)*



Have you had any problems with this body part before? _____

Are you under any restrictions from your doctor? If so, please list. _____

Have you fallen? If so, how many times this year? _____

MEDICATION *(please include prescription, non-prescription, blood thinners, and supplements)*

Medication	***Reason for taking medicine***

MEDICAL HISTORY

Do you currently have or have you ever had any of the following conditions? If yes, please explain on the lines below.

Heart Condition	**YES**	**NO**	**Fractures**	**YES**	**NO**
High Cholesterol	**YES**	**NO**	**Implanted Metal**	**YES**	**NO**
High Blood Pressure	**YES**	**NO**	**Adhesive Allergy**	**YES**	**NO**
Pacemaker	**YES**	**NO**	**Latex Allergy**	**YES**	**NO**
Cancer	**YES**	**NO**	**Pregnant**	**YES**	**NO**
Diabetes	**YES**	**NO**	**Difficulty w/ bowel control**	**YES**	**NO**
Asthma	**YES**	**NO**	**Difficulty w/ bladder control**	**YES**	**NO**
Communicable Diseases	**YES**	**NO**	**OTHER (list below)**	**YES**	**NO**

Please explain any "YES" answer(s). _____

I certify that I have completed this form to the best of my knowledge.

SIGNATURE: _____ **DATE:** _____