Longs Peak Family Practice

NEW SPORTS MEDICINE ONLY

Name: _____ Date of Birth: _____Date: _____

Please answer all questions accurately and completely.

List ALL diseases you are presently receiving treatment for, and any serious illnesses you have had in the past:

_____

List ALL medications/supplements you presently take regularly or occasionally, prescription, and non-prescription. Include dose and frequency: _____

_____

Are you allergic to any medications? Please list them plus your reaction:

_____

Have you ever had an operation? List date(s) and procedure(s):_____

_____

How many alcoholic beverages do you consume in a: week? _____ month?_____

Do you smoke or chew tobacco? YES/NO If so, how much? _____

How much caffeine do you consume per day?_____

What sports/exercises do you participate in and how often? _____

_____

What illnesses or diseases are in your family?

Mother: _____

Father: _____

Siblings: _____

Other: _____

Are you married? YES/ NO If so, how long have you been married? _____

Present Occupation: _____