Sports Medicine

@ Holy Name Medical Center
718 Teaneck Rd, Teaneck, NJ

@ HNH Fitness
514 Kinderkamack Road, Oradell, NJ

MEDICAL HISTORY FORM

Last Name: | First Name: | Date of Birth: | Today's Date:

MEDICAL HISTORY: *Please indicate if you (the patient) or any Family Members have any of the following:*

Condition	*Check if "Yes"*	*Check all that apply:*				
Arthritis	Patient: ☐	Family Member:	GrandParent: ☐	Parent: ☐	Sibling: ☐	Other: ☐
Asthma	Patient: ☐	Family Member:	GrandParent: ☐	Parent: ☐	Sibling: ☐	Other: ☐
Bleeding Disorder	Patient: ☐	Family Member:	GrandParent: ☐	Parent: ☐	Sibling: ☐	Other: ☐
Cancer	Patient: ☐	Family Member:	GrandParent: ☐	Parent: ☐	Sibling: ☐	Other: ☐
Diabetes	Patient: ☐	Family Member:	GrandParent: ☐	Parent: ☐	Sibling: ☐	Other: ☐
Heart Disease	Patient: ☐	Family Member:	GrandParent: ☐	Parent: ☐	Sibling: ☐	Other: ☐
High Blood Pressure	Patient: ☐	Family Member:	GrandParent: ☐	Parent: ☐	Sibling: ☐	Other: ☐
High Cholesterol	Patient: ☐	Family Member:	GrandParent: ☐	Parent: ☐	Sibling: ☐	Other: ☐
Kidney Disease	Patient: ☐	Family Member:	GrandParent: ☐	Parent: ☐	Sibling: ☐	Other: ☐
Liver Disease	Patient: ☐	Family Member:	GrandParent: ☐	Parent: ☐	Sibling: ☐	Other: ☐
Reflux (GERD)	Patient: ☐	Family Member:	GrandParent: ☐	Parent: ☐	Sibling: ☐	Other: ☐
Seizures	Patient: ☐	Family Member:	GrandParent: ☐	Parent: ☐	Sibling: ☐	Other: ☐
Stomach Ulcers	Patient: ☐	Family Member:	GrandParent: ☐	Parent: ☐	Sibling: ☐	Other: ☐
Stroke	Patient: ☐	Family Member:	GrandParent: ☐	Parent: ☐	Sibling: ☐	Other: ☐
Thyroid Disease	Patient: ☐	Family Member:	GrandParent: ☐	Parent: ☐	Sibling: ☐	Other: ☐

Other Conditions:

SURGICAL HISTORY: (Check here if "None"☐) *Please list any surgeries, include year (approximate year).*

Procedure:	Year:	Procedure:	Year:

MEDICATIONS: (Check here if "None"☐) *Please list current medications. Dosage information is not required on this form.*

Medication:	Medication:	Medication:	Medication:

ALLERGIES:

Medication Allergies: (Check here if "None"☐) *Please list medication patient is allergic to and associated reaction(s).*

Medication:	Reaction:	Medication:	Reaction:

Food Allergies: (Check here if "None"☐) *Please list food patient is allergic to and associated reaction(s).*

Food:	Reaction:	Food:	Reaction:

Other Allergies: (Check here if "None"☐) *Please list substance patient is allergic to and associated reaction(s).*

Allergen:	Reaction:	Allergen:	Reaction: