Wright State Physicians
SPORTS MEDICINE

HPI Form

Date: ____ / ____ /_____

Name: _____ **Birth Date:** ____/____/_____ **Age:** _____ Male or Female
First M.I. Last

Reason for today's visit: _____ Injured Side: Right Left Both

How did this injury happen: _____

Date symptoms began: _____ **How severe is your pain:** 0 1 2 3 4 5 6 7 8 9 10

Are your symptoms: Constant or Intermittent

Are your symptoms: Worsening, Unchanged or Improving

Previous injuries to this area? Yes or No

If you have had previous injuries to the area, please describe:_____

Did your injury occur at work? Yes or No **Occupation:** _____

How would you describe you pain?
Please check any that apply

- ☐ aching
- ☐ burning
- ☐ cramping
- ☐ dull
- ☐ fullness
- ☐ itching
- ☐ pressure
- ☐ sharp
- ☐ stabbing
- ☐ shooting
- ☐ throbbing
- ☐ tightness

Are you experiencing any of the following?
Please check any that apply

- ☐ stiffness
- ☐ swelling
- ☐ instability
- ☐ weakness
- ☐ limited range of motion
- ☐ numbness/tingling
- ☐ redness /warmth

What makes your symptoms worse? _____

What makes your symptoms better? _____

What treatments for this injury have you already tried?
Please check any that apply

- ☐Home exercise program
- ☐Physical therapy
- ☐Medication, if so what:_____
- ☐Injections, if so what type:_____
- ☐Other treatments: _____

What is/are your treatment goal(s)?

_____

_____

_____

Please answer **yes** or **no** below

Do you have acute symptoms of:

	Yes	No
Weight gain	☐	☐
Weight loss	☐	☐
Chest pain	☐	☐
Palpitations	☐	☐
Difficulty breathing	☐	☐
Nausea/vomiting	☐	☐
Weakness	☐	☐
Skin changes	☐	☐
Loss of consciousness	☐	☐
Dizziness	☐	☐
Headaches	☐	☐
Fatigue	☐	☐
Easy Bleeding	☐	☐

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Patient Health History

Date: ____ / ____ /_____

Name: _____
First M.I. Last

Birth Date: ____/____/_____

Please list your current medications: Check here if you are not taking any medications ☐

Medication Name:	Strength:	Instructions for use:

Please list any medical allergies you have : Check here if you have no drug or food allergies ☐
(medicines, latex, food) ☐ Seasonal allergies

Surgical History Check here if you have no history of previous surgery ☐

Medical History	Patient	Family Member
Anemia	☐	☐
Arthritis	☐	☐
Gout	☐	☐
Bone infection	☐	☐
Cancer	☐	☐
Concussion	☐	☐
Diabetes	☐	☐
Heart Disease	☐	☐
Hepatitis	☐	☐
High blood pressure	☐	☐
HIV/AIDS	☐	☐
Mental health/Depression	☐	☐
Osteoarthritis	☐	☐
Osteoporosis	☐	☐
Skin conditions	☐	☐
Stroke	☐	☐

☐ No Personal or Family Medical Issues

Social History Please Circle Below

Smoking Status: Never a smoker Former smoker Current everyday smoker Current occassional smoker

Smoking - How Much: None or _____ Pack(s) per day

Chewing Tobacco None 1 per day 2-3 per day 5+ per day

Alcohol Intake: None Occassional Moderate Heavy

How many days in past year have you had a heavy drinking comsumption? _____

Illicit Drug Use: None Occassional Moderate Heavy

Exercise Level: None Occassional Moderate Heavy