TEXAS SPORTS REHAB

Patient Demographic & Medical Information Form

Patient Name:_____ Parent/Guardian Name:_____

Home Ph:_____ Work Ph:_____ Cell Ph:_____

Address:_____ City:_____ State:_____ Zip code:_____

DL#:_____ SS#:_____ DOB:_____ Age:_____ Sex: M / F

Height:_____ Weight:_____ Tobacco Use? Yes No Explain:_____

Emergency contact person:_____ Relation to you:_____

Emergency Contact's Ph:_____ Alt. #:_____

Personal Physician's Name:_____ Office Ph:_____

How did you hear about us? _____

Are you currently experiencing or being treated for (please circle all that apply):

Heart Problems	Cancer	Respiratory Illness	Medications you are currently taking:
High/Low Blood Pressure	Ulcers	Viral Infections	_____
Stroke	Hernia	Seizures	_____
Dizziness/Headaches	Infectious disease	Skin Disorders	_____
Blood disorders	Diabetes	Sleep disorders	

Briefly explain any circled items: _____

_____

_____

List all known drug allergies:

_____

_____

_____

Have you ever had surgery? If yes, please explain:_____

_____

Have you ever had an extended hospital stay (more than 2 days):_____

_____

By signing this form I certify that all information is correct to the best of my knowledge.

Signature:_____ Date:_____