CORE
PERFORMANCE & WELLNESS

3121 University Dr. E, Suite 100 Bryan, TX 77802 | (979) 485-5470

Welcome to CORE!

Please refer to the following checklist to prepare for your appointment:

- Plan to arrive 10 minutes prior to your scheduled appointment.
- You will need to bring your I.D. and insurance card with you to your appointment. Copays will be collected at the check-in desk. We accept credit cards, cash and checks. Cash must be in exact change.
- If available, please bring prior medical records in person or fax to (979) 776-1372.
- We have enclosed a health questionnaire to be filled out completely and returned to our office before your appointment.
- ***Please note, that our office has a $50.00 cancellation fee within 24 hours of your appointment.***

If you have any questions or concerns regarding your appointment, please feel free to contact our office at (979) 485-5470 or via email at core@centexsportsmedicine.com

We are located next to the Physicians Center at 3121 University Dr E. Ste 100
Check in at Central Texas Sports Medicine front desk starting 3/11/19

Updated on October 10, 2018

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Full Name _____ **Date of Birth** _____ **Appointment Date** _____

Pharmacy Preference (include location) _____

Name of Primary Care (Family) Physician _____ **Referred by** _____

What is the reason for your visit today? _____

Height _____ **Weight** _____

CURRENT MEDICATIONS:

Are you taking ANY kind of medication now? (This includes prescription, over-the-counter or herbal medications)

☐ **Yes** ☐ **No** **If yes, please list below and *include dosages*.**

Medication	Dose	How often taken

MEDICATION ALLERGIES: ARE YOU ALLERGIC TO ANY MEDICATIONS? ☐ **Yes** ☐ **No** **If yes, please list below.**

Medication	Reaction (Hives, Anaphylaxis, Rash, Stomach Upset, Dizziness)

PAST MEDICAL HISTORY (***Please circle all that apply)***

Hypertension	HIV/AIDS	Headaches	Hepatitis A
Diabetes	Lung Disease	Eye Disorder	Hepatitis B
Heart Disease	Sleep Apnea	Glaucoma	Hepatitis C
Pacemaker	Stroke	Depression	Liver Disease
Arthritis	Seizures	Anxiety	Other:
Thyroid Disorder	Concussions	GERD	Other:
Bleeding Disorder	Migraines	Stomach Problems	

ARE YOUR IMMUNIZATIONS CURRENT? ☐ **YES** ☐ **NO**

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SURGERIES:

Date	Surgery

Have you been hospitalized for a non-surgical problem before? ☐ Yes ☐ No
If **yes**, list hospitalizations, the reason for admission and the date in the table below.

HOSPITALIZATIONS:

Date	Reason for Hospitalization

FAMILY HISTORY
Please check all that apply. For mental illness and cancer, please specify in the indicated box marked with **.

	Diabetes	*Hypertension*	*Heart Disease*	*Stroke*	*Mental Illness***	*Cancer***	*Arthritis*
Father	☐	☐	☐	☐	☐	☐	☐
Mother	☐	☐	☐	☐	☐	☐	☐
Siblings	☐	☐	☐	☐	☐	☐	☐
Paternal Grandfather	☐	☐	☐	☐	☐	☐	☐
Paternal Grandmother	☐	☐	☐	☐	☐	☐	☐
Maternal Grandfather	☐	☐	☐	☐	☐	☐	☐
Maternal Grandmother	☐	☐	☐	☐	☐	☐	☐
Children	☐	☐	☐	☐	☐	☐	☐
***** Please specify:*** _____							
Check here if family history is unknown: ☐							

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SOCIAL HISTORY

Do you consume Alcohol? ☐No ☐ Yes

If yes:

How often have you had a drink that contains alcohol in the past year?

☐ Monthly or Less ☐ 2-4x/Month ☐ 2-3x/Week ☐ 4+ times per week

How many drink do you typically have per ocassion?

☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ 7-9 ☐ 10+

How often have you had six or more drinks per ocassion in the past year?

☐ Less than Monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

Do you currently smoke? ☐No ☐ Yes ☐ I was a former smoker, but no longer smoke

Do you use recreational drugs? ☐No ☐ Yes

LIFESTYLE FACTOR REVIEW

Exercise

How often do you exercise per week?

☐ I don't currently exercise ☐ 1-2 times/week ☐ 3-4 times/week ☐ 5 or more days/week

If yes, How long do you typically exercise for?

☐ Less than 30 minutes ☐ 30-60 minutes ☐ More than 60 minutes

How would you rate the intensity of your exercise?

☐ Very light ☐ Moderate ☐ Hard ☐ Maximal intensity

What type of exercise do you enjoy? _____

Nutrition

How often do you eat on a typical day?

☐ Sporadically, no pattern ☐ 1-2 meals/day ☐ 3-4 meals/day ☐ 5 or more meals/day

Do you eat breakfast most days? ☐No ☐ Yes **How often do you grocery shop?** _____

How often do you eat out? _____ How often do you eat fast food: _____

Do you have any food allergies? ☐No ☐ Yes If yes, list them below:

_____

Describe a normal day's diet: *(include servings/amounts if known)*

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Drinks: _____

Do you drink soft drinks? ☐No ☐ Yes **If yes, how often?** _____

Do you drink coffee? ☐No ☐ Yes **If yes, how many cups/day?** _____

Do you currently take any supplements? ☐No ☐ Yes **If so, please list them in the space provided:**

_____

_____

Are you currently following a diet regiment? ☐No ☐ Yes **If so, what is the name?** _____

Have you had nutritional counseling in the past? ☐No ☐ Yes

Sleep

How many hours of sleep do you get on average each night? _____

How would you describe your sleep quality?

☐Poor ☐ Fair ☐ Good ☐ Great

Do you currently take any medication to improve sleeping? ☐No ☐ Yes
If yes, please list: _____

Stress

Rate your current overall stress level between 1 and 10: _____ (1 = very relaxed, 10 = very stressed)

Factors most contributing to your stress:

Health Work Money Family Other

What best helps you deal with your stress? _____

REVIEW OF SYMPTOMS

Please check all that apply

General Health Problems: ☐ No ☐ Yes

- ☐ Unintentional Weight Loss
- ☐ Unintentional weight Gain
- ☐ Fatigue
- ☐ Fevers
- ☐ Coldness
- ☐ Bruises Easily
- ☐ Loss of Appetite
- ☐ Swollen Glands of Lymph Nodes
- ☐ Night Sweats
- ☐ Skin Rash
- ☐ Trouble Sleeping
- ☐ Painful Urination
- ☐ Frequent Urination at Night

HEENT Problems: ☐ No ☐ Yes

- ☐ Changes in Vision
- ☐ Double Vision
- ☐ Changes in Voice
- ☐ Headaches
- ☐ Ringing in Ears
- ☐ Blurring Vision
- ☐ Dry Eyes
- ☐ Eye Irritation
- ☐ Photophobia

Heart or Blood Vessel Problems: ☐ No ☐ Yes

- ☐ Cold Extremities
- ☐ Irregular Heart Beat
- ☐ Heart Palpitations
- ☐ Chest pain
- ☐ Irregular heartbeat
- ☐ Leg Swelling
- ☐ Heart

Lung or Respiratory Problems: ☐ No ☐ Yes

- ☐ Chest Congestion
- ☐ Cough
- ☐ Shortness of breath
- ☐ Wheezing

Muscle or Bone Problems: ☐ No ☐ Yes

- ☐ Muscle Pain
- ☐ Bone Pain
- ☐ Joint Pain
- ☐ Leg Cramps

Stomach (Gastrointestinal): ☐No ☐ Yes

- ☐ Abdominal pain
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting
- ☐ Blood in Stool
- ☐ Changes in Bowel Habits
- ☐ Constipation

Brain or Nervous System Problems: ☐ No ☐ Yes

- ☐ Dizziness
- ☐ Insomnia
- ☐ Memory Loss
- ☐ Peripheral Neuropathy
- ☐ Restless Leg Syndrome
- ☐ Seziures
- ☐ Numbness &/or Tingling
- ☐ Weakness
- ☐ Tremor
- ☐ Vertigo

Problems with Glands, Hormones: ☐No ☐ Yes

- ☐ Cold Intolerances
- ☐ Excessive Sweating
- ☐ Excessive Thirst
- ☐ Heat Intolerance
- ☐ Sleep Disturbances
- ☐ Unwanted weight change

Blood or Lymph nodes Problems: ☐ No ☐ Yes

- ☐ Abnormal Bleeding
- ☐ Abnormal Bruising
- ☐ Enlarged Lymph Nodes
- ☐ Swollen Glands

Problems with Allergies: ☐ No ☐ Yes

- ☐ Food intolerances
- ☐ Itchy Eyes
- ☐ Stuffy Nose

Psychology: ☐ No ☐ Yes

- ☐ Anxiety
- ☐ Depression
- ☐ Eating Disorder
- ☐ High Stress Level
- ☐ Mental or Physical Abuse
- ☐ Sleep Disturbances
- ☐ Other Psychiatric Diagnosis

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How did you hear about CORE?

- ☐ Word of mouth/referred by a friend
- ☐ TV/Radio Ad
- ☐ Our website
- ☐ Search Engine
- ☐ Social Media (Facebook, Instagram, etc.)
- ☐ Blog Post
- ☐ Gym: _____
- ☐ Central Texas Sports Medicine
- ☐ Community Event (Race, Competition, Expo, etc.)
- ☐ Promotional Offer
- ☐ Walk in
- ☐ Other: _____