The Next Level Sports Medicine
James J. Lohse MD FAAFP CAQSM
4095 Mallory Lane
Franklin TN 37067
Tel: 615-850-5290
Fax: 615-777-3702
www.thenextlevelsportsmedicine.com

Patient Name: _____ Social Security #: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Marital Status: Single Married Divorced Widowed

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Sex: _____ Employer: _____

Responsible Party (If other than Patient):

Name: _____ Social Security #: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Marital Status: Single Married Divorced Widowed

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Sex: _____ Employer: _____

Primary Insurance Company: _____

Subscriber Name: _____

DOB: _____ Social Security #: _____

Member ID #: _____ Group #: _____

Secondary Insurance Company: _____

Subscriber Name: _____

DOB: _____ Social Security #: _____

Member ID #: _____ Group #: _____

Emergency Contact: _____ **Phone:** _____

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Patient Medical History Form

(Front and Back)

Name: _____ Date of Birth: _____

Referring Physician: _____

Pharmacy Name: _____ **Phone:** _____

Where is the Pain/Injury? _____

How long have you had symptoms: _____ How severe is your pain? _____

Circle appropriate description:

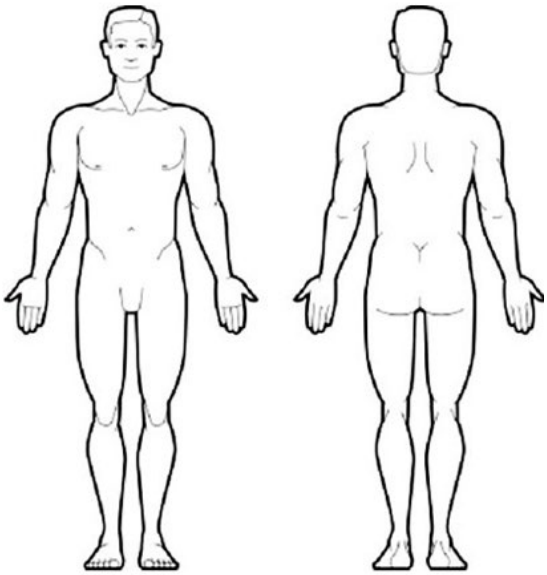
Sharp/Stabbing Dull Ache Numbness/Tingling/Burning Throbbing

When does your pain occur? _____

What makes pain feel better? _____

What makes pain worse? _____

Circle where pain is located:



Past Medical History

○ Asthma	○ Heart Attack	○ Rheumatoid Arthritis
○ Cancer	○ Hypertension	○ Skin Disease
○ Depression/Anxiety	○ High Cholesterol	○ Stroke
○ Diabetes	○ Osteoporosis	○ Thyroid
○ Lung Problems	○ Epilepsy	○ Ulcers
○ Kidney Problems	○ Gout	○ Prostate
○	○	○

Past Surgical History (List all Previous Surgical Procedures):

Medications:

Allergies (List the Names of Drug Allergies):

Family Medical History (List Family Members with the Following Conditions):

Arthritis	
Bleeding Condition	
Cancer	
Diabetes	
Heart Disease	
Osteoporosis	
Scoliosis	
Stroke	

Tobacco: YES ____ NO ____

Alcohol: YES ____ NO ____