



Name : _____

Date of Birth: _____

BODY PART : RIGHT / LEFT: _____

Is this injury (please circle): Work-related Auto Accident Sports Injury Other: _____

How did this happen? _____ Date of Injury/Onset: _____

Height: _____ Weight: _____ (lbs) Hand Dominance: RIGHT LEFT

How long have you had your symptoms? _____

Quality of your symptoms. (check all that apply below)

- | | |
|-----------------------------------|------------------------------------|
| <input type="checkbox"/> Aching | <input type="checkbox"/> Throbbing |
| <input type="checkbox"/> Tingling | <input type="checkbox"/> Sharp |
| <input type="checkbox"/> Burning | <input type="checkbox"/> Dull |
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Swelling |
| <input type="checkbox"/> Stabbing | <input type="checkbox"/> Pop |

What makes symptoms worse? _____

What makes symptoms better? _____

Please circle the number corresponding to your pain level:

0	1	2	3	4	5	6	7	8	9	10
No pain	Mild, annoying pain	Nagging, uncomfortable, troublesome pain	Distressing, miserable pain	Intense, dreadful, horrible pain	Worst possible, unbearable, excruciating pain					

Where are your symptoms?
(Please mark or shade on diagram)

Previous tests for your condition:

Check all that apply

- | | |
|------------------------------------|-------------------------------------|
| <input type="checkbox"/> X-Rays | <input type="checkbox"/> CT Scan |
| <input type="checkbox"/> MRI | <input type="checkbox"/> Ultrasound |
| <input type="checkbox"/> Bone Scan | <input type="checkbox"/> EMG |

Other: _____

Are you taking medication for this condition?

Previous treatments for your condition:

- | | |
|---|---------------------------------------|
| <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Occupational |
| <input type="checkbox"/> Cast | <input type="checkbox"/> ER Visit |
| <input type="checkbox"/> Splint/Brace | <input type="checkbox"/> Injections |

Other: _____

REVIEW OF SYSTEMS (PLEASE CHECK IF YOU HAVE HAD ANY OF THE FOLLOWING RECENTLY)

GENERAL

- Loss of appetite
- Fatigue
- Drenching night sweats
- Shaking Chills
- Fever
- Weight loss/gain

GENITAL/URINARY

- Prostate trouble
- Menstrual problems
- Urinary problems

CARDIOVASCULAR

- Racing heart
- Chest discomfort
- Dizzy spells/fainting
- Shortness of breath
- More pillows to breathe
- Swollen feet or ankles

SKIN

- Skin rashes/sores/moles
- Itching/burning
- Psoriasis

HEMATOLOGIC

- Anemia Bruises Easily
- Bleeding problems
- Enlarged glands

GASTROINTESTINAL

- Nausea or vomiting
- Constipation or diarrhea
- Abdominal pain
- Blood from rectum/tarry stools

MUSCULOSKELETAL

- Swollen joints Muscle Cramps
- Prior Fractures Osteoporosis

ENDOCRINE

- Heat/cold intolerance
- Frequent thirst
- Brittle nails/hair

EAR/NOSE/THROAT

- Nosebleeds
- Hearing difficulties
- Pain in ears
- Trouble with vision
- Dental problems

- Mouth sores or ulcers
- Glasses/Contacts
- Glaucoma

RESPIRATORY

- Wheezing
- Chronic cough
- Coughing up blood/phlegm
- Sleep Apnea

MOOD/PSYCH

- Lack of concentration
- Lonely or depressed
- Memory problems

NEUROLOGICAL

- Paralysis Weakness
- Alt. sensation (numbness)



Patient Label

SOCIAL HISTORY

Occupation (current or most recent): _____ Employer: _____

OR Check which apply: Student Retired Unemployed Disability/SSI

Who lives at home with you (name & age): _____

Goal activities/ sports/hobbies: _____

Are you a current smoker? _____ In the past? _____ Pack(s) per day _____ For how long have you smoked? _____ years

Do you drink alcohol? _____ If so, how much per week _____ When was your last drink _____

Do you use any recreational drugs? _____ If so, what type? _____

FAMILY HISTORY (PLEASE CHECK IF ANY OF YOUR BLOOD RELATIVES HAVE HAD ANY OF THE FOLLOWING)

ILLNESS	<input checked="" type="checkbox"/>	RELATIVE	ILLNESS	<input checked="" type="checkbox"/>	RELATIVE
Cancer	<input type="checkbox"/>		Arthritis	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>		Stomach problems/reflux	<input type="checkbox"/>	
High blood pressure	<input type="checkbox"/>		Thyroid disease	<input type="checkbox"/>	
Heart trouble	<input type="checkbox"/>		Sickle cell anemia	<input type="checkbox"/>	
Stroke	<input type="checkbox"/>		Depression	<input type="checkbox"/>	
Kidney disease	<input type="checkbox"/>		Epilepsy/seizures	<input type="checkbox"/>	
Bleeding disorders	<input type="checkbox"/>		Liver disease	<input type="checkbox"/>	
Blood clots	<input type="checkbox"/>		Asthma	<input type="checkbox"/>	
Other family illnesses:					

MEDICAL HISTORY (PLEASE CHECK IF YOU HAVE ANY OF THE FOLLOWING)

ILLNESS	<input checked="" type="checkbox"/>	ONSET	ILLNESS	<input checked="" type="checkbox"/>	ONSET
Cancer	<input type="checkbox"/>		Arthritis	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>		Stomach problems/reflux	<input type="checkbox"/>	
High blood pressure	<input type="checkbox"/>		Thyroid disease	<input type="checkbox"/>	
Heart trouble	<input type="checkbox"/>		Sickle cell anemia	<input type="checkbox"/>	
Stroke	<input type="checkbox"/>		Depression	<input type="checkbox"/>	
Kidney disease	<input type="checkbox"/>		Epilepsy/seizures	<input type="checkbox"/>	
Bleeding disorders	<input type="checkbox"/>		Liver disease	<input type="checkbox"/>	
Blood clots	<input type="checkbox"/>		Asthma	<input type="checkbox"/>	
HIV / AIDS / STD	<input type="checkbox"/>		COPD / Lung disease	<input type="checkbox"/>	
Hepatitis	<input type="checkbox"/>		Psychiatric	<input type="checkbox"/>	
Anemia	<input type="checkbox"/>		Tuberculosis	<input type="checkbox"/>	
Poor Vision	<input type="checkbox"/>		High Cholesterol	<input type="checkbox"/>	
Pregnancy:	Are you pregnant today? Yes No		If yes, Approx Due Date:		
Other medical illnesses:					

Have you had a flu vaccine for this flu season? YES NO If yes, when? _____
 Have you ever had the pneumococcal vaccine in the past 5 years? YES NO If yes, when? _____



Patient Label

DEMOGRAPHIC FORM

Patient Name: _____ DOB: _____

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

Home Phone #: _____ Cell Phone #: _____

Marital Status: (Circle) Single Married Widowed Divorced /Sep Spouses Name: _____

Emergency Contact: _____ Phone: _____

Relationship: _____

Family Physician : _____ Phone: _____

Referring Physician: _____ Phone: _____

PHARMACY INFORMATION

Pharmacy Name: _____ Phone Number: _____

Address/Location: _____ City/State: _____ Zip: _____

INSURANCE INFORMATION

Primary Insurance: _____

Cardholders Name: _____ Cardholders Date of Birth: _____

Secondary Insurance: _____

Cardholders Name: _____ Cardholders Date of Birth: _____

Are you willing to participate with research done in this office? YES or NO

Please list anyone by name that you give DMC Sports Medicine permission to speak to:

Name : _____ Relationship: _____

Name: _____ Relationship: _____

I authorized DMC Sports Medicine to discuss any of my protected health information with the above persons.

Signature of patient: _____

Printed name of patient: _____

Date: _____

Signature of witness: _____