DMC Sports Medicine

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? _____

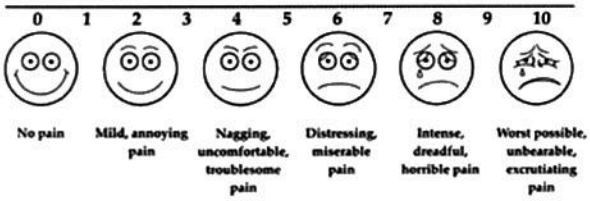
Quality of your symptoms. (check all that apply below)

- ☐ Aching
- ☐ Tingling
- ☐ Burning
- ☐ Numbness
- ☐ Stabbing
- ☐ Throbbing
- ☐ Sharp
- ☐ Dull
- ☐ Swelling
- ☐ Pop

What makes symptoms worse? _____

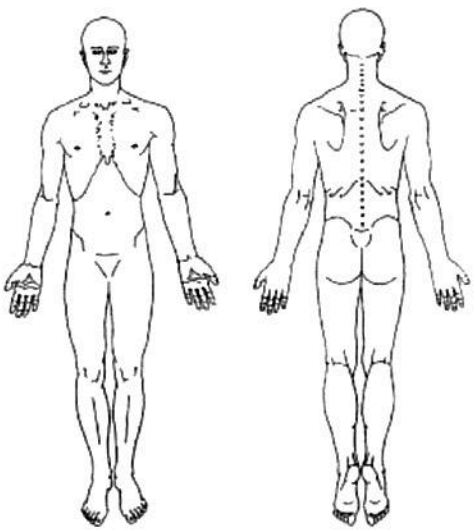
What makes symptoms better? _____

Please circle the number corresponding to your pain level:



Where are your symptoms?

(Please mark or shade on diagram)



Previous tests for your condition:

Check all that apply

- ☐ X-Rays
- ☐ CT Scan
- ☐ MRI
- ☐ Ultrasound
- ☐ Bone Scan
- ☐ EMG

Other: _____

Are you taking medication for this condition?

_____

_____

Previous treatments for your condition:

- ☐ Physical Therapy
- ☐ Occupational
- ☐ Cast
- ☐ ER Visit
- ☐ Splint/Brace
- ☐ 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)

DMC Sports Medicine

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	☑	Relative	Illness	☑	Relative
Cancer	☐		Arthritis	☐	
Diabetes	☐		Stomach problems/reflux	☐	
High blood pressure	☐		Thyroid disease	☐	
Heart trouble	☐		Sickle cell anemia	☐	
Stroke	☐		Depression	☐	
Kidney disease	☐		Epilepsy/seizures	☐	
Bleeding disorders	☐		Liver disease	☐	
Blood clots	☐		Asthma	☐	
Other family illnesses:					

Medical History (please check if you have any of the following)

Illness	☑	Onset	Illness	☑	Onset
Cancer	☐		Arthritis	☐	
Diabetes	☐		Stomach problems/reflux	☐	
High blood pressure	☐		Thyroid disease	☐	
Heart trouble	☐		Sickle cell anemia	☐	
Stroke	☐		Depression	☐	
Kidney disease	☐		Epilepsy/seizures	☐	
Bleeding disorders	☐		Liver disease	☐	
Blood clots	☐		Asthma	☐	
HIV / AIDS / STD	☐		COPD / Lung disease	☐	
Hepatitis	☐		Psychiatric	☐	
Anemia	☐		Tuberculosis	☐	
Poor Vision	☐		High Cholesterol	☐	
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? _____

DMC Sports Medicine

Patient Label

Medications

Medication—Include over the counter, Vitamins & Herbal	Dose

Allergies

Are you allergic to any medications? YES NO

If yes, please list:

Are you allergic to any of the following? (Check all that apply)

☐ Aspirin ☐ Penicillin ☐ Latex

Do you have any problems or reactions to anesthetic's? YES NO

If yes, describe:

Surgical and Hospitalization History

Month / Year	Hospital / Doctor	Diagnosis and/or Reason for Procedure

Physician Signature: _____ Date: _____

DMC Sports Medicine

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: _____