NORTHSIDE HOSPITAL
SPORTS MEDICINE
NETWORK

Date: _____

Patient name: _____ ☐ Male ☐ Female Date of birth: _____

Height: _____ Weight: _____ Age: _____ Dominant hand: ☐ Right ☐ Left

Primary care physician: _____ Who referred you: _____

Current employer: _____ Occupation: _____

Name of School/Team: _____ ☐ N/A Sport(s): _____ ☐ N/A

Reason for today's visit: ***(Please complete one form per body part)*** ☐ Second Option

Affected side: ☐ Right ☐ Left

Body part: ☐ Shoulder ☐ Upper arm ☐ Elbow ☐ Forearm ☐ Wrist ☐ Hand
☐ Hip ☐ Thigh ☐ Knee ☐ Lower Leg ☐ Ankle ☐ Foot
☐ Neck / back ☐ Other: _____

Main complaint: _____

Briefly describe how it happened _____

Is your complaint a result of an injury? ☐ Yes ☐ No Date of injury: _____

Work comp injury? ☐ Yes ☐ No If yes, are you currently working? ☐ Yes ☐ No

Average level of pain (0 - 10): _____ Worse At best (0 - 10): _____ Worse At worst (0 - 10): _____ Worse

Length of problem: _____ Have you had this problem before? ☐ Yes ☐ No

Course of problem: ☐ Improving ☐ Worsening ☐ Staying the same ☐ Recurring

Timing: ☐ Intermittent ☐ Constant

Quality: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Aching

Associated symptoms: ☐ Swelling ☐ Bruising ☐ Catching / locking ☐ Instability / giving away
☐ Heat ☐ Numbness ☐ Weakness ☐ Loss of motion
☐ Night pain ☐ Radiating down leg ☐ Other: _____

Aggravating symptoms: ☐ Bending over ☐ Reaching overhead ☐ Reaching behind back ☐ Lifting ☐ Throwing
☐ Siting ☐ Grasping ☐ Exercise ☐ Weight bearing ☐ Previous surgery
☐ Stairs ☐ Standing ☐ Running ☐ Squatting ☐ Twisting ☐ None

Alleviating symptoms: ☐ Laying down ☐ Rest ☐ Ice ☐ Heat ☐ Stretching / Exercise
☐ PT/OT ☐ Use of walker or cane ☐ Elevation ☐ Movement
☐ Limited weight bearing ☐ Siting ☐ None ☐ Other: _____

Prior evaluation or treatment for current problem: ☐ None

☐ X-rays ☐ ER/Office visit ☐ Cast / Splint ☐ Physical therapy / Occupational therapy
☐ MRI ☐ Injections ☐ Surgery ☐ Other: _____

NEW PATIENT

Past Medical History	
☐ High blood pressure	☐ Kidney disease ☐ Kidney stones
☐ Diabetes If yes, do you use insulin? _____	☐ HIV or AIDS ☐ Hepatitis Type _____
☐ Thyroid problems	☐ Tuberculosis ☐ Tick bite ☐ MRSA history
☐ Heart disease ☐ Heart attack ☐ Pacemaker	☐ Depression or psychiatric disorder
☐ Cancer Type?_____	☐ ADD/ADHD
☐ Blood clots (DVT/pulmonary embolism)	☐ Sickle cell anemia ☐ Anemia ☐ Bleeding problems
☐ Stroke ☐ Peripheral neuropathy	☐ Rheumatoid arthritis
☐ Rash/skin lesions	☐ Osteoporosis ☐ Osteoarthritis
☐ COPD ☐ Emphysema ☐ Asthma	☐ Seizures
☐ Concussion	☐ Trouble with anesthesia
☐ Reflux/GERD or ☐ Stomach ulcer	☐ Sleep apnea ☐ Use of CPAP
☐ Gout	☐ Other:_____

Family History (Please list family member) ☐ None
☐ High blood pressure
☐ Diabetes
☐ Heart disease
☐ Rheumatoid arthritis
☐ Cancer Type?_____
☐ Blood clots (DVT/pulmonary embolism)
☐ Bleeding problems
☐ Stroke
☐ Osteoporosis
☐ Asthma
☐ Trouble with anesthesia
☐ Other _____

Review of Systems				☐ None
Constitutional	☐ Fever	☐ Chills	☐ Weight loss	☐ Night sweats
Eyes	☐ Blurred vision	☐ Double vision	☐ Vision loss	
Ear/Nose/Throat	☐ Earache	☐ Hearing loss	☐ Throat pain	☐ Nose bleeds
Cardiovascular	☐ Chest pain	☐ Fast heart rate	☐ Palpitations	
Respiratory	☐ Cough	☐ Sleep apnea and ☐ Use of CPAP	☐ Difficulty breathing	☐ Wheezing
Gastrointestinal	☐ Nausea/vomiting	☐ Heartburn/ulcers	☐ Blood in stool	☐ Diarrhea
Genitourinary	☐ Painful urination	☐ Frequent urination	☐ Bladder/bowel changes	☐ Blood in urine
Musculoskeletal	☐ Joint stiffness	☐ Muscle aches	☐ Joint pain	☐ Muscle weakness
Skin	☐ Itching	☐ Skin lesion	☐ Skin rash	☐ Heat/cold tolerance
Neurologic	☐ Dizziness	☐ Vertigo	☐ Fainting	☐ Sensory/motor disturbances
Psychiatric	☐ Depression/Anxiety	☐ Drug/alcohol addiction	☐ Claustrophobic	☐ Sleep disorder ☐ Under care of Psychiatrist
Hematologic	☐ Easy bleeding	☐ Easy bruising	☐ Anemia	
Immunologic	☐ Hives	☐ Persistent infections		

List previous surgeries and dates: ☐ None

1. _____ Date:_____
2. _____ Date:_____

List current medications, dosages, and directions: ☐ None

1. _____ 3. _____
2. _____ 4. _____

List allergies and reactions: ☐ No known allergies

1. _____ 3. _____ ☐ **Latex** ☐ **Iodine**
2. _____ 4. _____ ☐ **Metal/Nickel**

Social History:

- Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widow
- Tobacco use: ☐ None ☐ Previous ☐ Current _____Amount/day
- Alcohol use: ☐ None ☐ Previous ☐ Current _____Amount/day
- Illegal drug use: ☐ None ☐ Previous ☐ Current If yes, what drug(s)? _____
- Physical Activity: How many days a week do you get moderate exercise? (e.g. Brisk walk) _____
  Duration: (e.g. Minutes) _____
- Are you currently **pregnant?**: ☐ Yes ☐ No **Nursing?**: ☐ Yes ☐ No
- Do you have any concerns about your safety?: ☐ Yes ☐ No

- **Flu shot** (this season): ☐ Yes (Date: _____) ☐ No ☐ Declined
- **Pneumonia shot** (if over 65): ☐ Yes (Date: _____) ☐ No

Signature:_____ Print name:_____ Date:_____

NEW PATIENT