VCUHS - Sports Medicine Clinic New Patient History Form

Place patient label here if available

Name: _____ Age: _____ Height: _____ Weight: _____

__ Unemployed or __ Employed Occupation: _____

Job status: __ working regular job __ working light duty __ not working due to this problem

Is this a work related injury? __ no __ yes Is it being covered by worker's comp? __ no __ yes

Is this a sports related injury? __ no __ yes Which sport? _____

Date of Injury: _____/_____/_____ Are you : __ Right handed or __ Left handed

Describe the problem you are currently experiencing: _____

How long has this been bothering you? _____ Circle any tests you have had for this problem: x-ray MRI CT scan

On a scale of 0 – 10, (10 is worst imaginable pain) how severe is your pain? _____ at rest and _____ with activities

Does it wake you from sleep? __ no __yes What makes the pain worse?_____

Pain is: __constant or __comes and goes Pain is: __sharp __dull __stabbing __throbbing __aching __burning

Do you have? __numbness __tingling __weakness __locking/catching __giving way __swelling __none of these

What treatments have you already tried? __ice __heat __rest __physical therapy __injections

Medications you have tried (both prescription and over the counter): _____

Medical History: Check yes or no to indicate if you are currently or have recently received treatment

Yes	No		Yes	No		Yes	No	
__	__	Anemia (low blood)	__	__	Diabetes	__	__	Recurrent infections
__	__	Arthritis	__	__	Heart Disease	__	__	Rheumatic Fever
__	__	Asthma	__	__	Hepatitis	__	__	Sexually transmitted diseases
__	__	Blood disorders (clotting, etc)	__	__	High Blood Pressure	__	__	Stomach ulcers
__	__	Cancer	__	__	Intestinal disorder	__	__	Stroke
__	__	Currently pregnant	__	__	Kidney disease			

Other: _____

Past Surgical History:

Surgery	Year	Surgeon/Hospital
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Name: _____

Immediate Family History: (your parents, siblings, and children) Check yes or no.

Disease	No family history	Yes – which relative?
Cancer	__	_____
Diabetes	__	_____
Heart Disease	__	_____
Arthritis	__	_____
Tuberculosis	__	_____

Social History:

Tobacco: __never smoked __smoked in the past but quit __currently smoke – how much? _____ how often?_____

Alcohol: __ do not drink __in recovery __ currently drink – how much? _____ how often?_____

Review of Symptoms: Please check any symptoms you have experienced in the past six months.

General:	___fever	___night sweats	___weight gain	___weight loss
Eyes:	___blurring	___eye strain	___contacts or glasses	
Ears:	___deafness	___ringing	___pain	___discharge
Nose:	___sinus drainage	___obstruction		
Throat:	___hoarseness	___difficulty swallowing		
Head:	___headaches	___fainting	___blackouts	___seizures
Stomach:	___vomiting	___belching	___diarrhea	___ nausea
Skin:	___rash	___cyanosis (blue skin)	___jaundice (yellow skin)	
Urinary:	___pain with urination	___frequent urination	___incontinence	
Neuro:	___weakness	___joint pain	___numbness/tingling	___loss of sensation
Cardiac:	___chest pain	___rapid heartbeat	___fainting	___leg swelling
Lungs:	___wheezing	___difficulty breathing	___productive cough	___coughing up blood

Patient Signature: X _____ Date: _____/_____/_____

MD Signature: _____ Date:_____/_____/_____