

WE VERIFY IDENTITY

SPORTS MEDICINE INSTITUTE

PATIENT PROBLEM QUESTIONNAIRE

Patient name: _____ Age: _____ DOB: _____

Please specify: R for right, L for left, B for both:

1. What part of the body are you being seen for? Hand _____ Wrist _____ Elbow _____ Shoulder _____
_____ Hip _____ Knee _____ Ankle _____ Foot _____ Other _____

2. Is your problem the result of an injury? _____ Yes _____ No. (If no, proceed to question #6)

3. What was the date of your injury? _____

4. How were you injured? Sports _____ Auto _____ A fall: _____ Other: _____

5. Where were you injured? Work. _____ School _____ Home _____ Other _____

6. How long have you had this problem? (Please specify a number). Days _____ Weeks _____ Months _____ Years _____

7. How would you describe the pain you are having? (mild, moderate, severe, stabbing, throbbing?)

8. What treatments have you had for this problem?

- _____ Anti-Inflammatory Medication
- _____ Injections
- _____ Physical therapy
- _____ Surgery
- _____ No treatment
- _____ Other:

9. How were you referred to us?

- _____ Primary Care Physician
- _____ Emergency Room
- _____ High School.
- _____ Other

10. Who is your primary Care Physician? _____

Physician's phone number? _____

11. Are you right or left-handed? _____ Right _____ Left.

Nurse notes: _____

Height _____ Weight _____ BP _____ HR _____

I hereby give consent to the SPORTS MEDICINE INSTITUTE to provide medical consultation and treatment for the above stated problem(s). I understand that I may, at any time, revoke this consent by providing written notice to the SPORTS MEDICINE INSTITUTE. Furthermore, I certify that all information furnished is true and correct. I am fully aware that it is a felony to falsify any information relating to my medical condition.

Patient signature (Guardian if Minor) _____ Date _____

I authorize the SPORTS MEDICINE INSTITUTE to release private health information it believes is necessary to further my treatment or care. I realize I may revoke this consent by providing written notice to the SPORTS MEDICINE INSTITUTE I realize by asserting this right, I may become responsible for coordinating my own care, including authorizations and payments for services needed.

Patient signature (Guardian if minor) _____ Date _____

SPORTS MEDICINE INSTITUTE MEDICAL HISTORY FORM

Patient Name: _____ Date: _____

I attest that the information below is true and correct: (Initials) _____

YOUR HEALTH HISTORY

Stroke Yes ___ No ___
Heart Trouble Yes ___ No ___
Diabetes Yes ___ No ___
Arthritis Yes ___ No ___
Gout Yes ___ No ___
Seizures Yes ___ No ___
Mental Illness Yes ___ No ___
Kidney Trouble Yes ___ No ___
Cancer Yes ___ No ___
Bleeding Disorder Yes ___ No ___
Alcoholism Yes ___ No ___
Serious Injury Yes ___ No ___
Lung Disease Yes ___ No ___
Tuberculosis Yes ___ No ___
Phlebitis Yes ___ No ___
Anemia Yes ___ No ___
Stomach Ulcer Yes ___ No ___
Liver Trouble Yes ___ No ___
Thyroid Trouble Yes ___ No ___
Other Illness Yes ___ No ___
High Blood Pressure Yes ___ No ___

Explain all YES answers:

Surgeries:

Current Medications and Dose:

Allergies to Medications: ___none

If Any Explain:

FAMILY MEDICAL HISTORY

Stroke Yes ___ No ___
Heart Trouble Yes ___ No ___
High Blood Pressure Yes ___ No ___
Diabetes Yes ___ No ___
Arthritis Yes ___ No ___
Gout Yes ___ No ___
Seizures Yes ___ No ___
Mental Illness Yes ___ No ___
Kidney Trouble Yes ___ No ___
Cancer Yes ___ No ___
Bleeding Disorder Yes ___ No ___
Alcoholism Yes ___ No ___
Other Illness Yes ___ No ___

SOCIAL HISTORY

Most Recent Occupation:

Married ___ Single ___ Divorced ___
Other _____

Number of Children Living: _____

Number of Pregnancies: _____

Presently Living Alone: ___ Yes ___ No

Smoke: ___ Yes ___ No

Alcohol: ___ Never ___ Occasional
Moderate to Heavy ___

Drug Overuse: ___ None ___ Presently
Past Problem ___

REVIEW OF SYSTEMS

Have you had, or do you have

Reading Glasses Yes ___ No ___
Change of Vision Yes ___ No ___
Loss Of Hearing Yes ___ No ___
Ear Pain Yes ___ No ___
Hoarseness Yes ___ No ___
Nosebleeds Yes ___ No ___
Difficulty Swallowing Yes ___ No ___
Morning Cough Yes ___ No ___
Shortness of Breath Yes ___ No ___
Chills or Fever Yes ___ No ___
Chest Pain Yes ___ No ___
Abnormal Heartbeat Yes ___ No ___
Badly Swollen Ankle Yes ___ No ___
Calf Cramps Yes ___ No ___
Poor Appetite Yes ___ No ___
Toothache Yes ___ No ___
Gum Trouble Yes ___ No ___
Nausea/Vomiting Yes ___ No ___
Stomach Pain Yes ___ No ___
Ulcers Yes ___ No ___
Frequent Belching Yes ___ No ___
Frequent Diarrhea Yes ___ No ___
Blood in Stool Yes ___ No ___
Constipation Yes ___ No ___
Hemorrhoids Yes ___ No ___
Frequent Urination Yes ___ No ___
Burning on Urination Yes ___ No ___
Difficult Starting Urine Yes ___ No ___
Difficult Stopping Urine Yes ___ No ___
Frequent Headaches Yes ___ No ___
Blackouts Yes ___ No ___
Seizures Yes ___ No ___
Frequent Rash Yes ___ No ___
Hot/Cold Spells Yes ___ No ___
Recent Weight Change Yes ___ No ___
Nervous Exhaustion Yes ___ No ___
Insomnia Yes ___ No ___
Depression Yes ___ No ___
Nervous Tension Yes ___ No ___

WOMEN ONLY

Irregular Periods Yes ___ No ___
Vaginal Discharge Yes ___ No ___
Frequent Spotting Yes ___ No ___

Are You Currently Pregnant?

Yes ___ No ___

Due Date: _____

**PLEASE NOTIFY DOCTOR AND
NURSE THAT YOU ARE PREGNANT
AS THIS MAY CHANGE YOUR CARE.**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY

Practices

[Physicians Business Alliance] reserves the right to modify the privacy practices outlined in the notice.

Signature

I have read and understand the Notice of Privacy Practices for [Physicians Business Alliance]

Name of Patient (Print or Type)

Signature of Patient

Date

Signature of Patient Representative
(Required if the patient is a minor or and adult who is unable to sign this form)

Relationship of Patient Representative to Patient