VCU Health

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:_____/_____/_____