Name: ____________________

Date of Birth: ____________________

BODY PART YOU ARE BEING SEEN FOR TODAY : ____________________ **RIGHT LEFT BOTH**

Is this injury(please circle): Work-related Auto Accident Sports Injury Other: ____________

How did this happen? ____________________

Date of Injury OR onset of symptoms: ____________________

Height: __________ Weight: __________ (lbs) Hand Dominance: RIGHT LEFT

Quality of your symptoms (check all that apply below)

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

What makes symptoms worse? ____________________

What makes symptoms better? ____________________

Please circle the number corresponding to your pain level:

0	1	2	3	4	5	6	7	8	9	10
No pain		Mild, annoying pain		Nagging, uncomfortable, troublesome pain		Distressing, miserable pain		Intense, dreadful, horrible pain		Worst possible, unbearable, excrutiating pain

Where are your symptoms?

(Please mark or shade on diagram)

Previous tests for your condition:

- ☐ 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 Therapy
- ☐ Cast
- ☐ Surgery
- ☐ Splint/Brace
- ☐ Injections

Other: ____________________

REVIEW OF SYSTEMS (PLEASE CIRCLE ANY THAT APPLY IN THE PAST 6 MONTHS)

GENERAL

Loss of appetite Fatigue
Drenching night sweats
Shaking Chills Fever
Weight loss/gain

CARDIOVASCULAR

Racing Heart Chest Discomfort
Dizzy Spells/Fainting
Shortness of Breath Swollen feet/ankles

HEMATOLOGIC

Anemia Bruise Easily
Bleeding Problems
Enlarged Glands

ENDOCRINE

Heat/Cold intolerance
Frequent Thirst
Brittle Hair/Nails

GENITAL/URINARY

Prostate trouble
Urinary problems
Menstrual problems

SKIN

Rashes/sores/moles
Itching/burning
Psoriasis

GASTROINTESTINAL

Nausea/Vomiting Constipation/Diarrhea
Abdominal pain
Bloody/Tarry Stools

MUSKULOSKELETAL

Swollen Joints Muscle Cramps
Fractures
Osteoporosis

MOOD/PSYCH

Lack of concentration
Lonely/Depressed
Memory Problems

NEUROLOGICAL

Weakness Paralysis
Numbness/Tingling

EAR/NOSE/THROAT

Nosebleeds Decreased Hearing
Pain in ears Decreased Vision
Dental problems Mouth sores/ulcers
Glasses/Contacts Glaucoma

PATIENT STICKER

SOCIAL HISTORY

Occupation (current or most recent): ______________________ Employer: ______________________

OR Check which apply: ☐ Student ☐ Retired ☐ SSI/Disability

Who lives at home with you (name & age)?: ______________________

Goal activities/sports/hobbies: ______________________

Are you a current smoker? YES / NO In the past? YES / NO Packs per day: ________ How long have you/did you smoke?: ________ yrs

Do you drink alcohol?: YES / NO If so, how much per week?: ________ When was your last drink?: ________

Do you use any recreational drugs?: YES / NO If so, what type?: ______________________

FAMILY HISTORY (PLEASE CHECK IF ANY OF YOUR IMMEDIATE FAMILY MEMBERS HAVE ANY OF THE FOLLOWING)

ILLNESS	☐	RELATIVE (CIRCLE WHICH ONE)	ILLNESS	☐	RELATIVE (CIRCLE WHICH ONE)
Cancer		Mother Father Sister Brother Grandparent	**Arthritis**		Mother Father Sister Brother Grandparent
Diabetes Type 1 2		Mother Father Sister Brother Grandparent	**Stomach problem/reflux**		Mother Father Sister Brother Grandparent
High blood pressure		Mother Father Sister Brother Grandparent	**Thyroid disease**		Mother Father Sister Brother Grandparent
Heart disease		Mother Father Sister Brother Grandparent	**Sickle cell anemia**		Mother Father Sister Brother Grandparent
Stroke		Mother Father Sister Brother Grandparent	**Depression**		Mother Father Sister Brother Grandparent
Kidney disease		Mother Father Sister Brother Grandparent	**Epilepsy/seizures**		Mother Father Sister Brother Grandparent
Bleeding disorders		Mother Father Sister Brother Grandparent	**Liver disease**		Mother Father Sister Brother Grandparent
Blood clots		Mother Father Sister Brother Grandparent	**Asthma**		Mother Father Sister Brother Grandparent
Other family illnesses:					

MEDICAL HISTORY (PLEASE CHECK IF *YOU* HAVE ANY OF THE FOLLOWING)

ILLNESS	☐	ONSET	ILLNESS	☐	ONSET
Cancer			**Arthritis**		
Diabetes Type 1 2			**Stomach problems/reflux**		
High blood pressure			**Thyroid disease**		
Heart disease			**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 had a COVID-19 vaccine? **YES** **NO** If yes, when was your last dose? ________

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PATIENT STICKER

Medications

MEDICATIONS—INCLUDE OVER THE COUNTER, VITAMINS & HERBAL	DOSE

Allergies

Are you allergic to any medications?

If yes, please list:

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

Aspirin Penicillin Latex Adhesive

Do you have any problems/reactions to anesthesia? YES NO

If yes, describe:

Surgical and Hospitalization History

Month/Year	Hospital/Physician	Type of surgery/Reason for hospitalization

Physician signature: ____________________ Date: __________

Patient Name: ______________________ DOB: ____________

Address: ______________________ City: ____________ State: ______ Zip: ________

Home Phone: ____________ Cell Phone: ____________ Email: ______________________

Marital Status: (Circle) Single Married Widowed Divorced /Sep Spouses Name: ____________

Emergency Contact: ____________ Phone: ____________ Relationship: ____________

Family Physician: ____________ City: ____________ Phone: ____________

Referring Physician: ____________ City: ____________ 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:** ____________

Please list anyone by name that you give DMC Sports Medicine permission to speak to:

Name: ______________________ Relationship: ____________

Name: ______________________ Relationship: ____________

I authorize DMC Sports Medicine to release medical information to above person(s).

Signature of patient/guardian: ______________________

Printed name of patient/guardian: ______________________ Date: ____________

Signature of witness: ______________________

Are you willing to participate with research done in this office? **YES or NO**