EMORY
SPORTS MEDICINE
CENTER

PATIENT INFORMATION SHEET

BACKGROUND

Name: _____Date: _____

Age: _____ Height: _____ Weight: _____ □ Right-Handed □ Left-Handed

- Occupation: _____
- Hobbies/Sports/Exercise Activities:_____
- Referring physician, school, or organization: _____
- Primary Care Physician/Address: _____
- Pharmacy name and address/phone number:_____

  _____
- What style of learning do you prefer? (check all that apply) □ See it □ Hear it □ Do it
- Do you have any barriers to learning? □ Yes □ No
  - If yes, please describe: _____

REASON FOR VISIT (Please provide a brief history of what is bothering you, what body part is injured, and how it happened): _____
_____
_____
_____

- How long have you had this problem? _____
  - Was there an injury? □ Yes □ No *If yes*, please provide the date of injury:_____
- On a scale of 0-10 (10 being the worst pain you can imagine), how bad is your pain: _____/10
- Have you seen another doctor for this problem? □ Yes □ No
  - If yes, when and what was the treatment? _____
- Have you had Surgery on this body part before? □ Yes □ No
  - If yes, when and please describe _____
- Other Treatments you've tried (circle): □ Ice □ Heat □ Brace □ Exercises □ Chiropractor
  □ Medications (please list: _____)
  □ Other _____

OVER PLEASE

EMORY
SPORTS MEDICINE
CENTER

PAST MEDICAL HISTORY

(Please choose all current and past medical conditions)

□ No medical problems	□ Emphysema	□ Kidney failure	□ Blood clots in legs/lungs
□ High blood pressure	□ Hepatitis	□ Endometriosis	□ HIV
□ Heart attack	□ Liver disease	□ Ovarian cysts	□ Alcoholism
□ Heart failure	□ Thyroid disease	□ Kidney stones	□ Anxiety
□ Abnormal heart rhythm	□ Diabetes	□ Osteoporosis	□ Depression
□ Lung disease	□ Irritable bowel	□ Osteoarthritis	□ Schizophrenia
□ Tuberculosis	□ Stomach ulcers	□ Rheumatoid arthritis	□ Anorexia/bulimia
□ Asthma	□ Stroke	□ Bleeding disorders	□ Cancer
□ Bronchitis	□ Seizures	□ Anemia	Type_____
□ Other: _____			

Are you under a doctor's care for any other medical condition? □Yes □No

If **yes**, please explain: _____

ALLERGIES: _____

MEDICATIONS:_____

PAST SURGERIES

(Please list ***any*** surgery and ***month/year*** of surgery)

_____

_____

FAMILY HISTORY

(Please indicate conditions that run in your ***close family (mom/dad/sibling/grandparents)***. If yes, please indicate relationship)

Condition	Family Member Relationship
□ Arthritis	_____
□ Heart disease	_____
□ High blood pressure	_____
□ Diabetes	_____
□ Bleeding disorder	_____
□ Cancer	_____ _____
What type?	_____ _____
□ Gout	_____
□ Mental illness	_____
□ Alcoholism	_____
□ Kidney disease	_____
□ Other: _____	

CONTINUED ON NEXT PAGE

EMORY
SPORTS MEDICINE
CENTER

SOCIAL HISTORY

- Do you smoke? □ Yes □ No □ Former – Year Quit_____
  - If yes, how many packs per day? _____
- Do you drink alcohol? □ Yes □ No
  - If yes, how many drinks per week? _____
  - If yes, what type of alcohol? (please circle) Beer Liquor Wine
- Use other drugs? □ Yes □ No
- Marital status: □ Married □ Single □ Divorced □ Widowed
- Children: □ Yes □ No How many? ____

REVIEW OF SYSTEMS (Have you experienced any of the following *recently*)

General
□ Fever
□ Chills
□ Night sweats
□ Fatigue/Tiredness
□Unplanned weight loss/gain
□Appetite change

Respiratory
□ Shortness of Breath
□Difficulty starting urination
□ Cough
□ Wheezing

Genitourinary
□ Painful Urination
□ Blood in Urine
□ Discharge
□ Testicular pain

Endocrine
□ Urinary Frequency
□ Increased Thirst
□ Increased Hunger

Skin
□ Rash
□ Itching
□ Dryness
□ Abrasions
□ Burns

Eye
□ Visual Changes
□ Pain
□ Discharge
□ Blurred vision
□ Double vision
□ Blindness

Cardiovascular
□ Palpitations /Fluttering in chest
□ Chest pain
□ Rapid Heart beat

Musculoskeletal
□ Muscle Pain
□ Joint Pain
□ Back Pain
□ Pain with Walking

Immunological
□ Seasonal Allergies
□ Food Allergies
□ Recurrent Infections
□ Impaired Immunity

Psychiatric
□ Anxiety
□ Depression
□ Sleeping Problems
□ Substance Abuse

Ears, Nose, Mouth, Throat
□ Ear pain
□ Pain
□ Discharge

Gastrointestinal
□ Nausea
□ Vomiting
□ Diarrhea
□ Constipation
□ Pain

Neurological
□ Headache
□ Dizziness
□ Numbness
□ Tingling
□ Weakness
□ Migraines

Hematological
□ Easily Bruising
□ Bleeding Tendency