Sports Medicine South
Atlanta's Orthopaedic & Sports Medicine Specialists

All questions contained in this questionnaire are strictly confidential and will become part of your medical record

Start Here— Use black pen or pencil and mark the ● circles completely. The questions and your answers are for the current problem you are seeing the physician for today unless specifically asked about previous problems.

GENERAL PATIENT INFORMATION

Today's date

Please print your name

Last Name

First Name MI

What is your height and weight?

Print numbers in the boxes.

Height: ft. in. Weight: lbs.

What is your dominant hand?

○ Right ○ Left ○ Ambidextrous

How did you hear about our office?

Mark ● ONE circle.

○ ER ○ Physician ○ Friend
○ Internet ○ Newspaper ○ Radio
○ Phone book ○ Other—*Print other below.*

Who is your family physician?

Print full name.

Who is the physician that referred you to our office?

Print full name.

CURRENT CONDITION

1. What is your primary orthopaedic problem today? *Mark ● ONE circle*

○ Pain ○ Tingling ○ Instability
○ Stiffness ○ Numbness ○ Weakness
○ Swelling ○ Other—*Print below*

2. Where is the location of your primary orthopaedic problem? *Mark ● ONE circle*

Upper Extremity

Arm	○ R	○ L	○ B
Shoulder	○ R	○ L	○ B
Elbow	○ R	○ L	○ B
Forearm	○ R	○ L	○ B
Wrist	○ R	○ L	○ B
Hand	○ R	○ L	○ B
Thumb	○ R	○ L	○ B
Index	○ R	○ L	○ B
Middle	○ R	○ L	○ B
Ring	○ R	○ L	○ B
Pinky	○ R	○ L	○ B

Lower Extremity

Lower Leg	○ R	○ L	○ B
Pelvis	○ R	○ L	○ B
Hip	○ R	○ L	○ B
Thigh	○ R	○ L	○ B
Knee	○ R	○ L	○ B
Calf	○ R	○ L	○ B
Ankle	○ R	○ L	○ B
Foot	○ R	○ L	○ B
Great Toe	○ R	○ L	○ B
2nd digit	○ R	○ L	○ B
3rd digit	○ R	○ L	○ B
4th digit	○ R	○ L	○ B
5th digit	○ R	○ L	○ B

Neck/Back

○ Neck ○ Lower Back
○ Upper Back ○ Buttocks
○ Mid Back
○ Other—*Print below*

INJURY INFORMATION

3. If today's problem is due to an injury or accident, where did the injury or accident take place?

Mark ● ONE circle

○ Home ○ School ○ Sports
○ Motor Vehicle Accident (See 3a)
○ Work related (See 3b)
○ Other—*Print below*

CONTINUE on page 2.

a. If your condition is due to a motor vehicle accident answer the questions below.
• Do you have an attorney representing you?
○ No ○ Yes
If yes, name of the attorney representing you.

• Where were you when the accident happened? ○ Driver ○ Passenger ○ Pedestrian
• If you were the passenger, where were you sitting?
○ Front Seat ○ Back Seat
• Were you wearing a seat belt?
○ No ○ Yes
b. If your condition is due to a work accident or injury answer the questions below.
• Name of the employer where the work injury or accident occurred.

• Date reported to your employer
• ○ Not reported

4. How did the injury or accident occur?
Please write complete sentences in the space below.

5. Have you had prior injuries of a similar nature? ○ No ○ Yes *If yes, explain below.*

PRIOR TREATMENT

6. Have you been treated for this problem in the Emergency Room? ○ No ○ Yes
a. If yes, which Emergency room or Hospital were you treated.

b. What treatment did you receive.

c. Were you admitted to the hospital.
○ No ○ Yes

7. Have you been seen by another physician for this problem? ○ No ○ Yes
a. If yes, who was the treating physician?

8. Select the past testing you've had done for this problem.
○ X-rays ○ MRI ○ Bone Scan
○ CAT Scan ○ Discogram ○ EMG
○ Ultrasound ○ Lab Tests
○ Other—*Print other below*

9. Have you received Physical Therapy for this problem? ○ No ○ Yes
a. If yes, where did you receive your Physical Therapy treatment?

b. How long did you receive Physical Therapy?
○ < 1 month ○ 1 month
○ 2 months ○ 3-6 months
○ 7-12 months ○ Over 1 year

MEDICAL & SURGICAL HISTORY

10. In the space provided, list all other medications you are taking including non-prescription medications
○ None

11. Do you have any allergies?
○ No known allergies.
○ Sulfa ○ Penicillin ○ Latex
○ Iodine dyes ○ Anesthesia ○ Codeine
○ Feathers ○ Eggs ○ Animals
○ Adhesive Tape ○ Environmental
○ Other—*Print other below*

12. Select past medical conditions.
○ No significant medical history
○ Anemia ○ Asthma
○ Bleeding Disorder ○ Blood Transfusions
○ BPH/Prostate dis. ○ Bronchitis
○ Cancer ○ COPD
○ Coronary Artery dis ○ Depression
○ Diabetes ○ Elev. Cholesterol
○ Angina/Arrhythmia ○ Fibromyalgia
○ GERD ○ Glaucoma
○ Gout ○ Hypertension
○ Intestinal Disease ○ Kidney/Renal Disease
○ Liver dis./Hepatitis ○ Obesity
○ Osteoarthritis ○ Osteoporosis
○ Osteomyelitis ○ Peripheral Vascular

CONTINUE on page 3.

Continue question #12.

- ○ Phlebitis
- ○ Rheumatoid Arthritis
- ○ Seizures
- ○ Stomach Ulcers
- ○ Stroke/TIA/CVA
- ○ Thyroid Disease
- ○ Other—*Print other below*

13. Have you had any surgeries?

- ○ No surgeries
- ○ Appendectomy
- ○ Arthroscopy Knee
- ○ Arthroscopy Shoulder
- ○ Back Surgery
- ○ Bowel Surgery
- ○ Carpal Tunnel Release
- ○ Gall Bladder
- ○ Hernia
- ○ Hip Replacement
- ○ Hysterectomy
- ○ Knee Replacement
- ○ Malignancy
- ○ Neck Surgery
- ○ Rotator Cuff Repair
- ○ Other—*Print other below*

FAMILY HISTORY

14. Select your father's medical conditions.

- ○ No medical conditions
- ○ Arthritis
- ○ Cancer
- ○ Diabetes
- ○ Gout
- ○ Heart Disease
- ○ Hereditary Defects
- ○ High Blood Pressure
- ○ Stroke
- ○ Tuberculosis
- ○ Other—*Print below*

a. What is your father's health status?

○ Living ○ Deceased ○ Unknown

15. Select your mother's medical conditions.

- ○ No medical conditions
- ○ Arthritis
- ○ Cancer
- ○ Diabetes
- ○ Gout
- ○ Heart Disease
- ○ Hereditary Defects
- ○ High Blood Pressure
- ○ Stroke
- ○ Tuberculosis
- ○ Other—*Print below*

a. What is your mother's health status?

○ Living ○ Deceased ○ Unknown

16. Select your sibling's medical conditions.

- ○ No medical conditions
- ○ Arthritis
- ○ Cancer
- ○ Diabetes
- ○ Gout
- ○ Heart Disease
- ○ Hereditary Defects
- ○ High Blood Pressure
- ○ Stroke
- ○ Tuberculosis
- ○ Other—*Print below*

a. What is your sibling(s) health status?

○ All living ○ All deceased
○ Some living/some deceased
○ Unknown

PERSONAL & SOCIAL HISTORY

17. What is your marital status?

Mark ● ONE circle

○ Single ○ Married ○ Divorced
○ Separated ○ Widowed

18. Do you live alone? ○ No ○ Yes

19. Are there stairs in your home?

○ No ○ Yes

20. What is your level of Education/ School?

- ○ N/A
- ○ Less than 12th grade
- ○ Trade/Vocational
- ○ Professional
- ○ Current Student
- ○ High School
- ○ College

21. Do you drink caffeinated beverages?

Mark ● ONE circle ○ No ○ Yes

a. If yes, how many per day?

○ 1-2 cups/cans ○ 3-4 cups/cans
○ 5+ cups/cans

22. Do you drink alcohol? *Mark ● ONE circle*

○ No ○ Yes

a. If yes, how frequently do you drink?

○ Rarely ○ Socially (2 to 3 per week)
○ Daily

23. Do you smoke tobacco?

Mark ● ONE circle ○ No ○ Yes

a. If yes, how many per day?

○ Less than one pack ○ One pack
○ Two packs ○ Three+ packs

b. How many years have you smoked?

○ 1-5 years ○ 6-10 years
○ 11-20 years ○ 20+ years

24. Do you have a history of recreational drug use? *Mark ● ONE circle*

○ No ○ Yes ○ Prior use

REVIEW OF SYSTEMS

25. Select all problems you have had in the last 6 months?

- ○ No problems in the last 6 months
- ○ Abdominal pain
- ○ Anxiety
- ○ Bone pain
- ○ Burning urination
- ○ Chest pain
- ○ Chronic cough
- ○ Constipated
- ○ Depression
- ○ Diarrhea
- ○ Difficulty Urinating
- ○ Irregular heartbeat
- ○ Leg cramps
- ○ Loss of coordination
- ○ Muscle spasms
- ○ Nausea
- ○ Numbness
- ○ Other joint pain
- ○ Other muscle pain
- ○ Palpitations
- ○ Rashes

CONTINUE on page 4.

- Discharge
- Disoriented
- Fainting
- Fatigue
- Fevers
- Frequent urination
- Headaches/Migraines
- Hearing loss
- Heartburn
- High blood pressure
- Hives
- Hoarseness
- Incontinence
- Weight loss unexplained
- Other—*Print below*
- Ringing in ears
- Shortness of breath
- Skin ulcers
- Sore throat
- Sweats
- Trouble swallowing
- Vision changes
- Vomiting
- Weakness
- Weight gain
- Weight loss
- Wheezing

HISTORY OF PRESENT ILLNESS

26. When was the onset of the current problem?

- Unknown
- Gradually
- Suddenly, without injury
- Suddenly, after an injury or accident
  a. Date of injury or accident.
- Gradually after an injury or accident
  a. Date of injury or accident.

27. Since the onset, what is the status of your symptoms?

- Improved
- Worsening
- No change

28. How long have the symptoms been present?

Mark ● ONE circle.

- Not sure

	1	2	3	4	5	6	7	8	9	10	11
Days	○	○	○	○	○	○					
Weeks	○	○	○	○							
Months	○	○	○	○	○	○	○	○	○	○	○
Years	○	○	○	○	○	○	○	○	○	○	○

29. On the scale below, mark the severity of your pain, 10 being the highest.

Mark ● ONE circle

	None		Mild			Moderate				Severe		
	0	1	2	3	4	5	6	7	8	9	10
Right	○	○	○	○	○	○	○	○	○	○	○
Left	○	○	○	○	○	○	○	○	○	○	○

30. How can the current problem be characterized?

- Aching
- Burning
- Constant
- Intermittent
- Sharp
- Stabbing
- Cramping
- Dull
- Other—*Print below*
- Throbbing

31. What additional symptoms are you experiencing?

- Chills
- Difficulty Walking
- Fatigue
- Fever
- Headaches
- Instability
- Limit of motion
- Loss of bladder control
- Other—*Print below*
- Loss of feeling
- Numbness
- Pain
- Radiation of pain
- Sleep disturbance
- Stiffness
- Swelling
- Tingling
- Weakness

32. Symptoms improve with:

- Activity
- Elevation
- Heat
- Ice/Cold
- Medication
- Rest
- Other—*Print below*

33. Symptoms feel worse with:

- Activity
- Bending
- Climbing stairs
- Heat
- Ice/Cold
- Sitting
- Walking
- Other—*Print below*

34. Are the symptoms worse during the day or night?

- No difference
- Day
- Night

Please sign and date this form

Signature Date

Please return your completed form to the front desk.