NAME _____ DOB _____ Age _____

Name of primary care doctor _____

Did your doctor send you here? (ÔK22ăŜ) Yes

Which body part hurts? _____ Right ☐ Left ☐

Pain level (cK22ăŜ) minor=1 Major=10 10

Pain quality (ÔK22ăŜ) aching

How long has this been bothering you? (date of onset) _____

How did this happen? Brief summary _____

_____

Have you ever had this problem before? (cK22ăŜ) no

What makes it better? (i.e. rest, activity, meds, sleep, etc) _____

What makes it worse? _____

Height: **feet** **inches** **Race:** American Indian _____ Asian _____ Black _____ Native Hawaiian _____White _____

Weight: **lbs** Type Unknown _____ **Preferred Language:**_____

Ethnicity: Hispanic Origin ____ Non Hispanic Origin ____ Type Unknown ____

MEDICAL PROBLEMS	**ALLERGIES & REACTIONS** **NONE** ☐
	MEDICATIONS
PAST SURGERIES **DATE**	
	IF ADDITIONAL SPACE NEEDED, PLEASE NOTIFY STAFF

SOCIAL HISTORY

Do you use tobacco? (cK22ăŜ) quit If quit, when? _____

How many packs/day? ____

How many years did you or have you smoked? ____

Do you drink Alcohol? (ÔK22ăŜ) no LŦ ĕŜăĭ K2ø YdžÔK _____

Marital Status (cK22ăŜ) Widowed

Number of children? _____

Occupation _____

If you are a student, where? What grade? _____

REVIEW OF SYSTEMS **Please highlight or circle all that apply to you now or that you have experienced recently**

General-weight change, fever or chills, fatigue, lumps or masses RiƎKűhanded ◉ LeŦűKanŘŜŘ ◯

Ears, Eyes, Nose & Throat - visual change, hearing change/ringing, bleeding gums, hoarseness

Gastrointestinal – diarrhea, constipation, difficulty swallowing, heartburn, bloody stools, black tarry stools, nausea, vomiting, jaundice

Cardiovascular – chest pain, irregular heartbeat/palpitations, heart murmurs, elevated blood pressure

Neurologic – seizures, paralysis, numbness, weakness, loss of consciousness, dizziness, headaches

Genitourinary – painful, bloody or frequent urination, incontinence, sexually transmitted disease, menopause

Respiratory –shortness of breath, cough, wheezing, night sweats, sputum production

I agree that Access Sports medicine may request and use my prescription medication and history from other healthcare providers or third-party pharmacy benefit payors for treatment purposes. All the above information has been reviewed today , updated as necessary and is complete to the best of my knowledge.

Date	**Patient signature**	**Physician/midlevel signature**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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