NYU Langone MEDICAL CENTER

Center for Musculoskeletal Care Sport Medical Questionnaire

Patient Information

Patient Name: _____ **Date:** _____

Date of Birth: _____ **Age:** _____ **Referral Source:** _____

Gender: **Male:** ☐ **Female:** ☐ **Occupation:** _____ **Do you play any sports?** _____ **Hand Dominance:** **Right** ☐ **Left** ☐

History of Complaint

What is the reason for your visit today? _____

What area(s) of the body is involved? _____ **When did the Pain Start?** _____

Is this the result of an Injury? ☐ **Yes** **or** ☐ **No**

Cause of Injury ☐ **Work** ☐ **Auto** ☐ **Sport** ☐ **Unknown** ☐ **Other** _____

Explain how and where this problem or injury occurred and the symptoms: _____

What makes the symptoms worse? _____

What makes the symptoms better? ☐ **Ice** ☐ **Heat** ☐ **Rest** ☐ **Elevation** ☐ **Other** _____

Is the problem /injury getting: ☐ **Better** ☐ **Worse** ☐ **Same**

Treatment for this Condition

Previous injury to this area? ☐ **Yes** **or** ☐ **No** **If YES, When?** _____

Have you been treated by any other physician and/or hospital for this problem? ☐ **Yes** **or** ☐ **No**

If Yes. Where? _____ **When?** _____

Treatment included: _____

☐ **Surgery** _____

☐ **Physical Therapy** **Location**

Injections ☐ **Cortisone** ☐ **Hyaluronic Acid** ☐ **Viscosupplementation (Euflexxa, Synvisc, Orthovisc, Hyalgan)** ☐ **Other** _____

☐ **Brace** ☐ **Cane / Crutch** ☐ **Emergency Room - Hospital** _____

Have you had: ☐ **X-Rays** ☐ **MRI** ☐ **Bone Scan** ☐ **EMG/NVC** ☐ **CAT Scan** ☐ **Other** _____

Have you obtained an Attorney? ☐ **Yes** **or** ☐ **No**

If YES, Attorney Name and Phone Number: _____

Patient Medical History — Please mark all conditions you currently have

☐ Asthma	☐ History of Blood Clots	☐ Sleep Apnea ☐ Use of CPAP
☐ Anemia	☐ High Blood Pressure	☐ Polio
☐ Cancer	☐ Jaundice	☐ Rheumatic Fever
☐ COPD	☐ Kidney Disease	☐ Thyroid
☐ Heart Disease/Heart Failure	☐ Stroke	☐ Stents ☐ Tuberculosis

☐ Diabetes - Controlled By: ☐ Insulin ☐ Medication ☐ Diet ☐ None

☐ Hepatitis Type: ☐A ☐B ☐C ☐ HIV ☐ Other

☐ HIV ☐ Other Diseases _____

Date of Last Tetanus Shot? _____

Did You Ever Have a Blood Transfusion? ☐ **Yes** ☐ **No**

Medications List **Please print any medications you are currently taking. Include the Medication Name and dosage amount.**

_____ _____ _____

_____

Are you taking blood thinners?: COUMADIN ASPIRIN PLAVIX

Allergies List **Please print all known allergies.** ☐ **No Known Allergies** ☐ **Latex Allergies** ☐ **Yes I have allergies (list)**

_____ _____ _____

Surgical History **Please print all surgeries you have had and when.** ☐ **No Past Surgeries**

_____ _____ _____

Post Operation Complications? **Yes** ☐ **No** ☐

Family Medical History **Please mark if any relatives have had any of the conditions below, include which relative.**

Does any relative have the medical condition you are being seen for? **No** ☐ **Yes** ☐ **- Relationship** _____

☐ Cancer	_____	☐ High Cholesterol	_____
☐ Diabetes	_____	☐ Kidney Disease	_____
☐ Heart Disease	_____	☐ Rheumatoid Arthritis	_____
☐ Clotting Disorder	_____	☐ Stroke	_____
☐ High Blood Pressure	_____	☐ Thyroid	_____

Social History

Do you use Tobacco Products? Yes ☐ No ☐

If YES, how much per day? _____ **If No, did you Quit?** Yes ☐ No ☐ **When?** _____

Do you consume Alcohol? Yes ☐ No ☐ **If YES, how much per week?** _____

Review or Systems **Do you have any of the conditions listed below? Check all that apply to you.**

Musculoskeletal:	☐ Rheumatoid Arthritis	☐ Gout	☐ Osteoporosis	☐ Fractures	☐ Other	_____
Gastrointestinal:	☐ Heartburn ☐ Ulcers	☐ Nausea/Vomiting	☐ Liver Disease	☐ Blood in Stool	☐ Other	_____
Endocrinology:	☐ Frequent Thirst	☐ Frequent Urination		☐ Always Hot of Cold	☐ Other	_____
Constitution:	☐ Weight Gain / Loss	☐ Loss of Appetite		☐ Frequent Fever	☐ Other	_____
Eye:	☐ Glasses / Contacts	☐ Vision Loss	☐ Blurred Vision	☐ Double Vision	☐ Other	_____
ENT:	☐ Hearing Loss	☐ Hoarseness	☐ Trouble Swallowing	☐ Other	_____	
Cardiovascular:	☐ Chest Pain	☐ Palpitations	☐ Heart Attack	☐ Other	_____	
Respiratory:	☐ Chronic Cough	☐ Shortness of Breath		☐ Other	_____	
Genitourinary:	☐ Painful Urination	☐ Blood in Urine	☐ Bowl/ Bladder Loss	☐ Kidney Failure	☐ Other	_____
Skin:	☐ Frequent Rashes	☐ Skin Ulcers		☐ Psoriasis	☐ Other	_____
Neurologic:	☐ Headaches	☐ Dizziness		☐ Seizures	☐ Other	_____
Psychological:	☐ Depression	☐ Drug / Alcohol Problems		☐ Sleep Disorders	☐ Other	_____
Hematologic:	☐ Easy Bleeding	☐ HIV/AIDS	☐ Hemophilia	☐ When _____	☐ Other	_____

Work History

Occupation: _____ **Are you retired?** Yes ☐ No ☐

Current Employer: _____ **Job Title:** _____

Date you last worked your regular job? _____ **Date you worked any job?** _____

If you are working, is it modified in any way? Yes ☐ No ☐

If YES, what are your restrictions: _____

_____

Physician Signature _____ **Date:** _____