UC San Diego
HEALTH SYSTEM

Sports Medicine

OFFICE USE ONLY: PATIENT STICKER

GENERAL INFO

Name:______________________ Date of Birth:____________ Age:________

Email Address:______________________ May we contact you via email? Y N

Primary Care Provider: ______________________ May we send them updates on your care? Y N

Who referred you to our clinic? ______________________ May we send them a thank you letter? Y N

CURRENT PROBLEM

Location of injury: ☐ Left ☐ Right ☐ Both What body part is injured (shoulder, knee, ankle, etc)? ______________

Dominant hand: ☐ Left ☐ Right ☐ Both Date of injury: ______________

Did injury occur from:
☐ Sports? .... If so, which sport?______________
☐ Work?.................. If so, worker's comp claim #: ______________
☐ Motor vehicle accident?.......... If so, is litigation involved? ☐ Yes ☐ No
☐ Other?______________

Please provide the details of how your injury occurred? ______________

____

SYMPTOMS

Please **RATE** your pain:

No Pain ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 Worst Pain Ever

QUALITY of pain :	Other SYMPTOMS:		STATUS of symptoms:	WHEN are symptoms most severe:	What makes symptoms WORSE?	What makes symptoms BETTER?
☐ Sharp	☐ Stiffness	☐ Bruising	☐ Worsening	☐ Morning	☐ Rest	☐ Rest
☐ Dull	☐ Instability	☐ Swelling	☐ Stable	☐ Afternoon	☐ Activity	☐ Activity
☐ Throbbing	☐ Catching	☐ Numbness	☐ Improving	☐ Evening	☐ Sleeping	☐ Ice
☐ Stabbing	☐ Popping	☐ Tingling	☐ Constant	☐ Consistent all day	☐ Kneeling	☐ Medication
☐ Aching	☐ Locking	☐ Weakness	☐ Occasional	☐ Interrupts Sleep	☐ Other:	☐ Brace
☐ Heavy	☐ Other:		☐ Other:	☐ Other:		☐ Other:
☐ Burning						
☐ Other:						

TREATMENTS

Have you: ☐ Seen another physician for this injury? If so, who did you see______________ & when________
☐ Had surgery in the past for this problem? If so, what surgery______________ & when________

What treatments have you tried?	Were the treatments helpful?		What treatments are you interested in receiving?	What studies have you had for this problem?
☐ Massage therapy	☐ Yes	☐ No	☐ Physical therapy	☐ X-rays
☐ Physical therapy	☐ Yes	☐ No	☐ Surgery	☐ MRI
☐ Chiropractic therapy	☐ Yes	☐ No	☐ Bracing	☐ CT scan
☐ Acupuncture	☐ Yes	☐ No	☐ Injection	☐ EMG (nerve study)
☐ Bracing	☐ Yes	☐ No	☐ Medication	☐ Bone scan
☐ Injections	☐ Yes	☐ No	☐ Other:	☐ Ultrasound
☐ Medication:	☐ Yes	☐ No		☐ Other:
☐ Other:	☐ Yes	☐ No		

PAST MEDICAL HISTORY

Have you ever been hospitalized? ☐ Yes ☐ No If yes, please explain______________

____

Please identify if you have previously suffered from:

☐ Depression/anxiety	☐ Seizures	☐ High blood pressure	☐ High cholesterol	☐ Arthritis	☐ MRSA
☐ Eating disorder	☐ Vertigo	☐ Heart disease/attack	☐ Peptic ulcer	☐ Osteoporosis	☐ Heart murmur
☐ HIV/AIDS	☐ Asthma	☐ Stroke	☐ Hepatitis/liver disease	☐ Seizures	☐ Nerve injury
☐ Cancer	☐ Sleep apnea	☐ Bleeding disorder	☐ Reflux (GERD)	☐ Diabetes	☐ RSD/CRPS
☐ Pulmonary embolism	☐ Tuberculosis	☐ Blood clots (DVT)	☐ Kidney disease	☐ Thyroid	☐ Fibromyalgia

ALLERGIES

Are you allergic to LATEX? ☐ Yes ☐ No

Are you allergic to IODINE ☐ Yes ☐ No

Are you allergic to FOODS? ☐ Yes ☐ No If yes, which foods? ____________________

Are you allergic to MEDICATIONS? ☐ Yes ☐ No If yes, which medications?____________________

MEDICATIONS

Please list all of your current prescription medications, over-the-counter medications, and nutritional supplements:

MEDICATION	DOSE	FREQUENCY

SURGICAL HISTORY

Please list all surgeries you have had in the past, including complications (bleeding, infection, blood clots, anesthesia reaction, etc):

SURGERY	DATE	SURGEON	COMPLICATIONS

REVIEW OF SYSTEMS

Do you currently have any of the following medical issues?

SYSTEM	Y or N	DESCRIBE IF ANSWERED "YES"
General (weight gain/loss, chills, fever, fatigue, insomnia)	☐ Yes ☐ No	
Skin (rash, itching, masses, blisters, dermatitis, eczema, psoriasis, poor wound healing)	☐ Yes ☐ No	
Eyes (glasses/contacts, cataracts, blurred, vision, glaucoma)	☐ Yes ☐ No	
Ear/Nose/Throat (hearing loss, ringing, nose bleeds, hoarseness, snoring)	☐ Yes ☐ No	
Heart (irregular heartbeat, chest pain, fluttering in chest)	☐ Yes ☐ No	
Lungs (shortness of breath, lung disease, frequent cough, wheezing)	☐ Yes ☐ No	
Stomach (constipation, heartburn, nausea, diarrhea, vomiting)	☐ Yes ☐ No	
Urinary Tract (kidney stones, infection, prostate problems)	☐ Yes ☐ No	
Muscles/Bones (arthritis, fibromyalgia, stiffness, muscle aches)	☐ Yes ☐ No	
Neuro (fainting, poor balance, seizures, tingling, numbness, headaches)	☐ Yes ☐ No	
Mental Health (anxiety, depression, eating disorder)	☐ Yes ☐ No	
Endocrine (hot flashes, excessive thirst, hot/cold intolerance)	☐ Yes ☐ No	
Blood / Lymph (easy bruising/bleeding, clotting problems, anemia)	☐ Yes ☐ No	
Immunologic (HIV/AIDS, lupus, polio, TB)	☐ Yes ☐ No	

FAMILY HISTORY

Please identify if any of your family members have had the following:

☐ Anesthesia problems
☐ Anxiety/Depression
☐ Arthritis
☐ Osteoporosis
☐ Bleeding/Clotting
☐ Cancer
☐ Diabetes
☐ Heart disease
☐ High blood pressure
☐ Kidney disorder
☐ Stroke
☐ Other:

SOCIAL HISTORY

Are you currently employed? ☐ Yes ☐ No Occupation:____________ Employer:____________

Are you disabled from work? ☐ Yes ☐ No If yes, when were you last able to work?____________

Marital status: ☐ Single ☐ Married ☐ Partner ☐ Divorced ☐ Widowed

Number of children: ____________

Current use or history of tobacco use: ☐ Yes ☐ No Amt per day: ____________ Duration: ________ Quit Date:__________

Alcohol use: ☐ Yes ☐ No Amt per week:____________ ☐ History of abuse Quit Date:__________

Recreational drugs: ☐ Yes ☐ No Type:____________ ☐ History of abuse Quit Date:__________

Exercise:
☐ Sedentary, no exercise
☐ Mild (climbing stairs, walk 3 blocks, golf)
☐ Occasional, vigorous (less than 4x/wk x 30 min)
☐ Regular, vigorous (4+ x/wk, x 30+ min)

What physical activities or hobbies do you participate in? ____________________

Is there anything else you'd like to share with us? ____________________

PATIENT SIGNATURE:____________________ DATE:____________