Cincinnati Children's Hospital Medical Center

Sports Medicine Follow Up Questionnaire

Place Sticker or Print Name here:

_____

1. What are we seeing you for today? _____
2. Which side? *Left* *Right* *Both*
3. When did we last see you? *(give date if known)* _____
4. Since your last visit, how are you overall? *Better* *Same* *Worse*
5. Are you having any pain? *Pain Today* *Pain, but not today (Recurrent/Chronic)* *No pain*
   Related to today's visit? *Y N* If no pain today, date of last episode: _____
6. What is it like? *Sharp* *Throbbing* *Aching* *Dull* *Burning* *Spasm* *Hurts* *Can't Describe* *Other:*
7. How often? *Constant* *Several times a day* *Once daily* *Few days a week* *Rarely* *Other:*
8. How long does it last? *0-30 minutes* *30-60 minutes* *1-2 hours* *2-4 hours* *Other:*
9. How severe is it? *0 (none) 1 2 3 4 5 6 7 8 9 10 (worst ever)*
10. What have you tried for it? *Nothing* *Medications* *Ice or Heat* *Rest* *Splinting* *PT* *Other:*
11. What makes it worse? _____ Better? _____
12. Does it radiate? *Y N* If so, to where? _____
13. Do you have any: *Locking* *Catching* *Painful Popping* *Instability/Giving Out* *Swelling*
14. Is this limiting what you can do? *Y N* If so, how? _____
15. Are there any events coming up that you would like to return to? _____
16. Have there been any new injuries or new symptoms since your last visit? *Y N*
    If so, please explain: _____

18. If there are any changes to your medical history, family medical history, or home/school/work, please list:

_____

_____

19. Have you developed any of the following symptoms since the last visit? (circle)

General	*Fever* *Unexplained change in weight* *Fatigue (more than usual)*
ENT	*Sore throat*
Ophthalmologic	*Vision Problems*
Pulmonary	*Wheezing*
Cardiovascular	*Chest pain* *Fainting or almost fainting with exercise*
Gastrointestinal	*Nausea* *Vomiting* *Abdominal Pain*
Neurologic	*Headache* *Weakness* *Numbness / Tingling* *Sensation Loss*
Urologic	*Pain with Urination*
Males only	*Testicle pain*
Females only	*Delayed or missed periods*
Psychologic	*Depressed mood* *Anxiety or excessive worry* *Sleep difficulties*
Lymphatic	*Swollen lymph nodes*
Allergic	*Pollen or food allergies*
Immunologic	*Frequent infections*
Dermatologic	*Rash*
Musculoskeletal	*Other joint pain or swelling not mentioned above*

NONE OF THE ABOVE