Cincinnati Children's Hospital Medical Center

Sports Medicine
New Patient Questionnaire

Place Sticker or Print Name here:

_____

1. Who suggested you see us today? *Primary Care Dr* *Emergency/Urgent Care* *Trainer* *Other* *Self*
2. What is their name and/or clinic name? _____
3. What are we seeing you for today? _____
4. Which side? *Left* *Right* *Both*
5. When did it start? *(give date if known)* _____
6. How did it start? *Injury* *Gradual Onset* *Other*

   Please describe: _____
7. 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: _____
8. What is it like? *Sharp* *Throbbing* *Aching* *Dull* *Burning* *Spasm* *Hurts* *Can't Describe* *Other:*
9. How often? *Constant* *Several times a day* *Once daily* *Few days a week* *Rarely* *Other:*
10. How long does it last? *0-30 minutes* *30-60 minutes* *1-2 hours* *2-4 hours* *Other:*
11. How severe is it? *0 (none) 1 2 3 4 5 6 7 8 9 10 (worst ever)*
12. What have you tried for it? *Nothing* *Medications* *Ice or Heat* *Rest* *Splinting* *PT* *Other:*
13. Has anyone seen you for this? *No* *Primary Care Dr* *Specialist* *Other:*
14. What makes it worse? _____
15. What makes it better? _____
16. Does it radiate? *Y N* If so, to where? _____
17. Do you have any: *Locking* *Catching* *Painful Popping* *Instability/Giving Out* *Swelling*
18. Have you had any special tests done for this, such as x-rays or an MRI? *Y N*

    If so, please list: _____
19. Have you ever had this problem before? *Y N*
20. Is this limiting what you can do? *Y N* If so, how? _____
21. Are there any events coming up that you would like to return to? _____

22. Do you play any sports? *Y N*

    Currently in-season: _____

    Currently off-season: _____
23. What school do you attend? *(Please spell out name)* _____
24. What grade are you in? _____
25. Do you have an athletic trainer at your school? *Y N* If yes, name/contact number if available: _____
26. Do we have permission to talk with the trainer about your condition if it affects school or sports participation? *Y N*
27. Left-handed OR Right-handed?

28. What allergies to medications do you have? _____
29. What medications are you currently taking? _____
30. Are you usually healthy? *Y N*

    If no, please list chronic medical conditions: _____
31. Do you have any conditions that run in the family? *Y N*

    If so, please list: _____

32. Are you currently experiencing any of the following symptoms? (circle)

General Health	*fever recent weight loss or gain (0.5 kg) more fatigue, tiredness than usual*
Ear, nose, throat (ENT)	*postnasal drip infections, sinusitis hearing loss, blocked nose pain, sore throat sneezing, hoarse voice itchy nose, swollen glands in neck*
Ophthalmologic	*decreased vision, itchy eyes pain in the eyes, discharge from the eye red eyes increased or decreased tear production*
Pulmonary system	*asthma wheezing hay fever painful breathing repeated flu-like illness cough*
Cardiac and Vascular system	*chest pain at rest chest pain while working out passed out (syncope) with exercise personal history of high blood pressure irregular heartbeats*
Gastro-intestinal	*heartburn nausea vomiting abdominal pain liver, pancreatic, or gallbladder disease? weight loss or gain (0.5 kg) change in bowel habits chronic diarrhea blood in stools*
Neurological	*frequent headaches muscle weakness dizziness nerve tingling blackouts loss of sensation muscle cramps anxiety attacks chronic fatigue history of stroke or transient ischemic attack (TIA)*
Urological	*blood in urine frequent urination groin/loin pain burning during urination kidney stones kidney disease testicular pain, mass, or irregularity*
Females only	*menstrual irregularities missed, heavy periods*
Psychological	*depression anxiety/excessive worry high level of stress difficulty staying/falling asleep*
Hematological system	*low iron stores anemia (in particular iron deficiency anemia)*
Allergies	*pollen foods to any medication any plant material any animal material*
Infection / Immunological	*current infections recurrent infections HIV / AIDS*
Dermatological	*skin rashes skin infections itchy skin allergies skin cancer*
Endocrine / Metabolic	*diabetes mellitus thyroid gland disorders hypoglycemia (low blood sugar) more heat intolerance than usual more cold intolerance than usual*

Diet and Nutrition

Have you been consciously trying to restrict the amount of food you eat to influence your shape or weight?
Have you gone long periods of time (8 hours or more) without eating in order to influence your shape or weight?
Have you attempted to avoid eating any foods that you like in order to influence your shape or weight?
Have you attempted to follow definite rules regarding your amount of food, or rules about what or when you should eat?
Have you had a definite desire for your stomach to feel empty?

NONE OF THE ABOVE