Attach patient sticker here

SPORTS MEDICINE CENTER
Children's Hospital Colorado

PATIENT INFORMATION

Preferred Name: ______________________ School/District: ___________________ Grade: _______

Sports/Activities: ____ Club: ___________________

VISIT INFORMATION

What are you being seen for today? ____

Was there an injury?

Yes – Date of Injury ________ How did it occur? ____

No – How long have symptoms been present? ____

Have you been seen by anywhere else for this complaint? ☐ Yes No

Where? ED/UC PCP Athletic trainer Other ___________________

Has any imaging been performed? ☐ Yes No

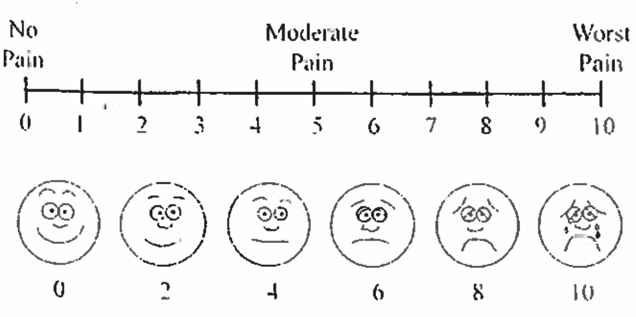
Date of imaging ____________ X-rays CT scan ☐ MRI Other _______________

PAIN (check all that apply): ☐ Dull ☐ Sharp ☐ Stabbing ☐ Burning ☐ Achy ☐ Throbbing

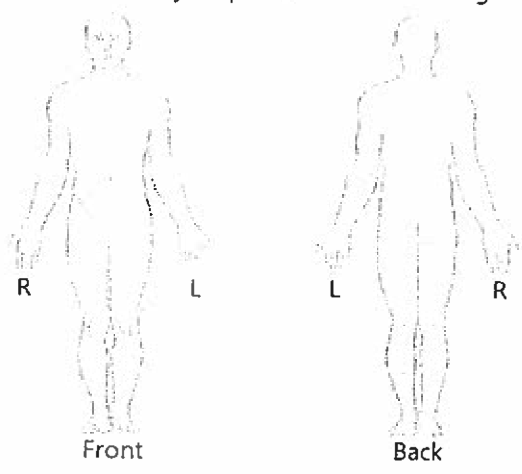
☐ Shooting ☐ Squeezing ☐ Pressure ☐ Cramping

Using the scale below, please rate your pain (0-10):

At rest:____ With daily routine:____ With physical activity:_____



Where is your pain? Mark the drawing



What makes it better? ____

What makes it worse? ____

List any medications being taken to treat the pain: Tylenol/Acetaminophen Advil/Motrin/Ibuprofen

☐ Other (please list)____

(TURN OVER TO COMPLETE ADDITIONAL HEALTH INFORMATION)

MEDICAL HISTORY

Please list current or previous health conditions: ______________________________

Please list any surgeries: ______________________________

Please list current supplements and medications (prescription and over-the-counter):

______________ ______________ ______________

______________ ______________ ______________

ALLERGIES: None Medications ______________

Food ______________ Environmental/Seasonal ______________

FAMILY HISTORY

Does anyone in your family have any of the following problems? (Check all that apply)

Orthopedic problems (bone or joint injury/surgery) Bleeding/clotting problems Nerve problems

Anesthesia Complications Osteoporosis Other: ______________

Rheumatoid Arthritis / Lupus/ Rheumatologic Disease

SOCIAL HISTORY

Who lives in your household? ______________________________

HEALTH HABITS: Smoking exposure? _ Yes _ No

CURRENT SYMPTOMS OR PROBLEMS Please check any that currently apply to you:

Allergy/Immunologic
- Allergies
- Immune system problems

Cardiovascular
- Irregular heart beat
- Swollen legs or feet
- Heart disease
- Chest pain
- Heart murmur

Constitutional
- Recent weight change
- Fatigue / weakness
- Change in appetite or thirst
- Fever, chills

Dermatologic
- Skin rash / disease

Endocrine
- Thyroid problems
- Growth problems

Gastrointestinal
- Stomach pain / heartburn
- Ulcers
- Change in bowel habits (also blood in stool)
- Hepatitis or gallbladder disease

HEENT
- Vision problems / eye disease
- Nose / throat problem
- Hearing problems / ear disease

Hematologic/Oncologic
- Blood disorder or blood transfusion
- Easy bleeding or bruising
- Cancer

Neurologic
- Frequent headaches
- Fainting spells
- Seizures
- Problems with coordination

Psychiatric
- Depression/Anxiety

Reproductive
- Sexually transmitted disease
- Menstrual problems
- Pregnancy

Respiratory
- Shortness of breath or wheezing
- Frequent cough

Urologic
- Kidney disease or kidney stones
- Change in urinary habits (including pain, blood in urine, trouble stopping / starting your urine)