English

(Patient label here.)

UHealth
UNIVERSITY OF MIAMI HEALTH SYSTEM
SPORTS MEDICINE

Age: _____ Height: _____ Weight: _____ Email: _____

Primary Care Physician: _____ Referring Physician: _____

How did you hear about us?

☐ Doctor ☐ Family/Friend ☐ Insurance Company ☐ UHealthSportsMedicine.com
☐ University of Miami Athletics ☐ Miami Marlins ☐ South Florida Club Sport ☐ Other Sporting Event
☐ Bommarito Performance ☐ Gym/Fitness Center ☐ Newspaper ☐ Television

Please specify: _____

What problem or body part can we help you with today? _____

What was the date of injury? or How long have you had this problem? _____

Rate your pain on a scale of 0 to 10 (0 = no pain, 10 = worst pain you ever had).

Today: 0 1 2 3 4 5 6 7 8 9 10
At its worst: 0 1 2 3 4 5 6 7 8 9 10

Please rate how much the following activities are affected by this problem. (0=no effect, 10=unable to perform)

Sports: 0 1 2 3 4 5 6 7 8 9 10
Work: 0 1 2 3 4 5 6 7 8 9 10
Sleep: 0 1 2 3 4 5 6 7 8 9 10
Daily Activities: 0 1 2 3 4 5 6 7 8 9 10

How would you describe your pain? Check all that apply:

☐ constant ☐ on/off ☐ sharp ☐ dull
☐ achy ☐ burning ☐ pressure ☐ tingling/electrical

Has any other medical provider seen you for this problem? ☐ Yes ☐ No

If yes, who?_____

What was the diagnosis? _____

Have you had an X-ray for this problem? ☐ Yes ☐ No
Have you had an MRI for this problem? ☐ Yes ☐ No

If yes to any of the above:
When and where were they performed? _____
Did you bring them with you today? ☐ Yes ☐ No

Have you used any of these techniques for treatment and/or pain control? Check all that apply:

☐ Rest ☐ Ice ☐ Ibuprofen (Advil, Motrin) ☐ Physical Therapy (For how long? _____)
☐ Injection ☐ Heat ☐ Acetaminophen (Tylenol) ☐ Naproxen (Aleve) ☐ Splint/brace
☐ Other (please list) _____

Do you have any of the following symptoms?

☐ weakness ☐ swelling ☐ loss of motion ☐ locking ☐ catching ☐ clicking/popping
☐ redness ☐ tenderness to touch ☐ feeling of giving way/dislocation ☐ walking with limp
☐ numbness ☐ tingling ☐ unexplained weight loss ☐ fevers ☐ chills

CONTINUED ON OTHER SIDE

Are you right-handed or left-handed? ☐ Right ☐ Left

Do you take any medications? ☐ Yes ☐ No If Yes, please list below:

Name of Medication	Condition Treated	Name of Medication	Condition Treated

Do you have any allergies to medication? ☐ Yes ☐ No
If yes, to what? _____ Type of reaction: _____
Do you have an allergy to latex? ☐ Yes ☐ No
If yes, what kind of reaction do you have? _____

Have you had previous surgery? ☐ Yes ☐ No If Yes, please list below:

Side of Body	Body Part	Surgeon	Year
Left Right N/A			
Left Right N/A			
Left Right N/A			
Left Right N/A			
Left Right N/A			

Do you have a family history of any bone or joint problems? ☐ Yes ☐ No
If yes, please describe: _____

Do you have or have you ever had any of the following? Check all that apply:

☐ High blood pressure
☐ Heart disease/Heart attack
☐ Heart/Bypass surgery
☐ Angioplasty
☐ Blood clots
☐ Diabetes
☐ Kidney disease
☐ Asthma
☐ COPD/Emphysema
☐ Tuberculosis
☐ Seasonal Allergies
☐ Stomach ulcers
☐ Acid reflux/heart burn
☐ Rheumatoid arthritis
☐ Arthritis
☐ Cancer
☐ Hepatitis
☐ Migraine headaches
☐ Stroke
☐ Lupus
☐ Autoimmune disease

Do you have any other medical problems that you think we should know about? ☐ Yes ☐ No
If yes, please describe: _____
Do you smoke? ☐ Yes ☐ No If Yes, how many packs/day? _____ For how long? _____
Do you drink alcohol? ☐ Yes ☐ No If Yes, how many drinks/week?_____

Is this a Workers Compensation injury? ☐ Yes ☐ No If Yes, date of injury: _____
Are you currently working? ☐ Yes ☐ No If Yes, are you on light duty? ☐ Yes ☐ No
What is your occupation? _____
Are you a student? ☐ Yes ☐ No If Yes, what school?_____

Thank you for taking the time to provide this information to us. It is very helpful as we work to provide you with the most efficient and effective care possible. – UHealth Sports Medicine