

THE SPORTS MEDICINE CLINIC OF TAMPA

Roger C. Brainard, M.D.

William G. Carson, Jr., M.D.

3006 W. Azelee Street, Tampa, FL 33609 • (813) 874-3006 • Fax (813) 876-6258

Date _____

PATIENT NAME: _____

SS# _____

HOME ADDRESS: _____
LAST FIRST MIDDLE CITY ST ZIP

SEX: MALE FEMALE AGE: _____ DATE OF BIRTH: _____ HEIGHT: _____ WEIGHT: _____

HOME PHONE: (____) _____

WORK PHONE: (____) _____ EXT: _____ BEEPER: _____ CELL PHONE: _____

OCCUPATION: _____ PLACE OF EMPLOYMENT: _____

IF MARRIED, SPOUSE'S NAME _____ PHONE: (____) _____

IF MINOR, PARENT'S NAME: _____

DRIVER'S LICENSE # (Responsible Party) _____ STATE: _____

INSURED'S NAME: _____ D.O.B. _____ SS# _____

Name of Insurance Co. _____ POLICY # _____ GROUP # _____

WHO REFERRED YOU: _____ LIST OF PHYSICIANS YOU SEE: _____

CHIEF COMPLAINT (REASON FOR VISIT): _____

DATE OF INJURY _____ IS YOUR INJURY WORK RELATED? YES NO

WHAT SPORTS OR RECREATIONAL ACTIVITIES ARE YOU INVOLVED IN? _____

HISTORY OF PRESENT ILLNESS (HPI)

Location: _____
(Where on the body symptom occurs)

Duration: _____
(How long have you had symptom/pain? How long does it last?)

Severity: _____
(Severe, worse, slightly - pain scale 1-10?)

Quality: _____
(Character of symptom/pain ...burning, gnawing, stabbing)

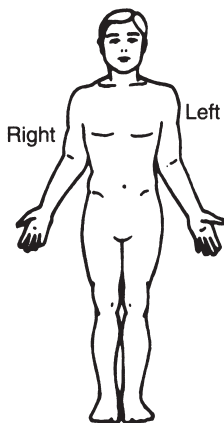
Timing: _____
(When symptoms occur .. after meals or exercise, etc.)

Context: _____
(Situations associated with pain)

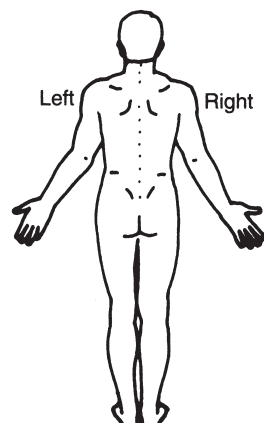
Factors: _____
(Things to make symptoms better or worse)

Associated Signs/Symptoms: _____
(Other things that happen when this pain occurs)

Recurrent Problems: _____



Please indicate areas of complaint with these symbols:
✓ Pain
○ Numbness
X Tingling



PHYSICIAN'S USE ONLY: _____

MEDICAL HISTORY**1.) Do you now have or ever had any of the following medical conditions?**

	Yes	No		Yes	No		Yes	No		Yes	No
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Acute Infections	<input type="checkbox"/>	<input type="checkbox"/>	Other Illness	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/gout	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>			
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	Hereditary Defects	<input type="checkbox"/>	<input type="checkbox"/>			
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Tendency	<input type="checkbox"/>	<input type="checkbox"/>	HIV	<input type="checkbox"/>	<input type="checkbox"/>			

Explain all yes answers: _____

2.) List all Previous Surgeries: (ie, tonsils, gallbladder, orthopaedic procedures, colonoscopy, etc.)

Date _____

Date _____

3.) List all Medications you take: _____**4.) Are you allergic to any medications?** Yes No **If yes, list medications:** _____**REVIEW OF SYMPTOMS:****5.) Do you have any problems related to the following:**

SYMPTOM	Yes	No	SYMPTOM	Yes	No	SYMPTOM	Yes	No	SYMPTOM	Yes	No
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Lack of Appetite	<input type="checkbox"/>	<input type="checkbox"/>	Bruising	<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain and/or	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Stiffness		
Dry Cough	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	Nose Bleeds	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Pain or	<input type="checkbox"/>	<input type="checkbox"/>
Productive Cough	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Seeing	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Cramps		
Difficulty Breathing	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Hearing	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Cramping	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Swallowing	<input type="checkbox"/>	<input type="checkbox"/>			
Swelling in the Legs	<input type="checkbox"/>	<input type="checkbox"/>	Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Sleeping	<input type="checkbox"/>	<input type="checkbox"/>			

6.) Are you Pregnant? Yes No **If so, make certain no x-rays are taken.****7.) PATIENT SOCIAL HISTORY:**

Marital Status: Single Married Separated Divorced Widowed Live Alone: Yes No
 Use of Alcohol: Never Rarely Moderate Daily
 Use of Tobacco Never Previously, but quit _____ Current packs per day _____
 Use of Drugs: Never Type / Frequency _____

8.) FAMILY MEDICAL HISTORY:

MEMBER	AGE	DISEASES	IF DECEASED, CAUSE OF DEATH	MEMBER	AGE	DISEASES	IF DECEASED, CAUSE OF DEATH
Father	_____	_____	_____	Spouse	_____	_____	_____
Mother	_____	_____	_____	Children	_____	_____	_____
Siblings	_____	_____	_____		_____	_____	_____
	_____	_____	_____		_____	_____	_____
	_____	_____	_____		_____	_____	_____

9.) EXCESSIVE EXPOSURE AT HOME OR WORK TO:

ITEM	Yes	No	ITEM	Yes	No	ITEM	Yes	No	ITEM	Yes	No
Fumes	<input type="checkbox"/>	<input type="checkbox"/>	Dust	<input type="checkbox"/>	<input type="checkbox"/>	Solvents	<input type="checkbox"/>	<input type="checkbox"/>	Air-Borne Particles	<input type="checkbox"/>	<input type="checkbox"/>
									Noise	<input type="checkbox"/>	<input type="checkbox"/>

Everything I have answered is correct and true to the best of my knowledge.

Date _____

Patient/Guardian Signature _____

INSURANCE MEDICAL RELEASE/ASSIGNMENT

I understand and agree that, (regardless of my insurance), I am ultimately responsible for the balance of any professional services rendered. I understand and agree that I may be charged 1.5% interest rate per month on any balance 90 days past due and that I am responsible for any costs incurred in collection of said balance. I hereby authorize this office to release information necessary to secure reimbursement from any insurance company to which I subscribe. I have read and understand the above and agree to comply.

Date _____

Signature _____

Physicians Signature _____

Date _____