

# THE SPORTS MEDICINE CLINIC OF TAMPA

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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)

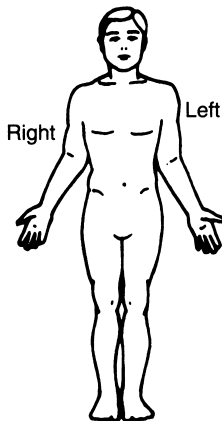
Timing: \_\_\_\_\_  
(When symptoms occur .. after meals or exercise, etc.)

Context: \_\_\_\_\_  
(Situations associated with pain)

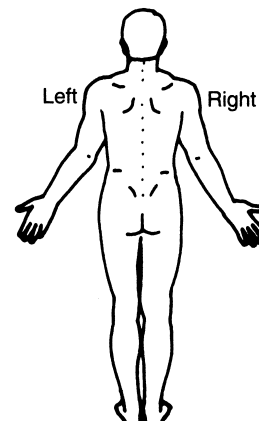
Factors: \_\_\_\_\_  
(Things to make symptoms better or worse)

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 \_\_\_\_\_