



34474-08

Children's Healthcare of Atlanta
Children's Physician Group - Orthopaedics

SPORTS MEDICINE
JOHN ALSOBROOK, MD AND JOHN BUCHANAN, DO

Name
Date of Birth
MRN#
Account/HAR#
PATIENT IDENTIFICATION

Patient Name:
Date of Birth:
Today's date:
Family members seen in office:
PCP:
Who referred you to our office?
MD Coach/Trainer Family Other
Name of School/ Athletic Association:
Coach's Name:

Problem: (No more than two problems per visit please)

- What will we be seeing you for at this visit?
Date of injury/How long have you had this problem?
Describe how and where the injury occurred or what initiated the symptoms:
Describe your symptoms:
Have you had prior injuries or surgeries to this area?
Do your current symptoms keep you awake at night?
How severe is your pain on a scale of 0-10?
What is the quality of your pain?
How often does your pain occur?
Do you have any of the following symptoms?
Since your problem started, is it:
What makes your symptoms worse?
What improves your symptoms?
Have you been treated for this by another physician/hospital?
Describe the treatment:
Have you already had x-rays?

Review of Systems: Do you have any of the following? (Check all that apply)

- Heartburn, Nausea, Vomiting, Chest Pain, Palpitations
Chronic Cough, Swelling of Extremities, Increased Weakness, Fever, Shortness of Breath
Chills, Rashes, Numbness, Tingling, Radicular Pain
DVT, Blood in Urine, Kidney Stones, Depression, Pulmonary Embolus
Sleep Disturbances, Sore Throat, Hearing Change, Blurry Vision
Double Vision, Hormonal Problems, Heat Or Cold Intolerance

Past Medical/Surgical History:
Medications:
Allergies and reaction types:

Personal History: tobacco use alcohol use caffeine use

Past Family History:

Cancer:
Tuberculosis:
Diabetes:
Other:
Hypertension:
Heart Disease:
Arthritis:

Patient/Parent/Guardian Signature:
Date:
Time:



34474-08

Children's Healthcare of Atlanta  
Children's Physician Group - Orthopaedics

**SPORTS MEDICINE**  
**JOHN ALSOBROOK, MD AND JOHN BUCHANAN, DO**

Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

MRN# \_\_\_\_\_

Account/HAR# \_\_\_\_\_

PATIENT IDENTIFICATION

### For in-clinic use only

Temp	HR	RR	B/P	Wt (kg)	Ht (cm)	HC	O2 Sat
------	----	----	-----	---------	---------	----	--------

Pain Score	Pain Scale
------------	------------

Staff Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_