34474-08

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

Name_____

Date of Birth_____

MRN#_____

Account/HAR#_____

PATIENT IDENTIFICATION

SPORTS MEDICINE
JOHN ALSOBROOK, MD AND JOHN BUCHANAN, DO

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? _____ ☐ Left ☐ Right ☐ Both
- Date of injury/How long have you had this problem? _____ Was there a specific injury? ☐ Yes ☐ No
- 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? ☐ Yes ☐ No If so what was the date of treatment? _____
- Do your current symptoms keep you awake at night? ☐ Yes ☐ No
- How severe is your pain on a scale of 0-10? 0 1 2 3 4 5 6 7 8 9 10
- What is the quality of your pain? ☐ Sharp ☐ Dull ☐ Stabbing ☐ Throbbing ☐ Aching ☐ Burning
- How often does your pain occur? ☐ Intermittent ☐ Constant
- Do you have any of the following symptoms? ☐ Sharp ☐ Numbness ☐ Tingling ☐ Weakness ☐ Redness
- Since your problem started, is it: ☐ Better ☐ Worse ☐ Unchanged
- What makes your symptoms worse? ☐ Standing ☐ Waling ☐ Running ☐ Jumping ☐ Lifting ☐ Bending ☐ Extending ☐ Twisting ☐ Squatting ☐ Kneeling ☐ Stairs ☐ Sitting ☐ Coughing/Sneezing ☐ Other
- What improves your symptoms? ☐ Rest ☐ Ice ☐ Heat ☐ Compression/Bracing ☐ Advil/Aleve/Tylenol ☐ Other: _____
- Have you been treated for this by another physician/hospital? ☐ Yes ☐ No Treating physician/ER _____
- Describe the treatment: _____
- Have you already had x-rays? ☐ Yes ☐ No

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:	☐ No ☐ Yes	Relationship: _____	Hypertension:	☐ No ☐ Yes	Relationship: _____
Tuberculosis:	☐ No ☐ Yes	Relationship: _____	Heart Disease:	☐ No ☐ Yes	Relationship: _____
Diabetes:	☐ No ☐ Yes	Relationship: _____	Arthritis:	☐ No ☐ Yes	Relationship: _____
Other:	☐ No ☐ Yes	Relationship: _____			

Patient/Parent/Guardian Signature: _____ Date: _____ Time: _____

PRINT SAVE AS RESET

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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:_____