34474-08

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

DR. MARSHALL SPORTS MEDICINE FORM

Name_____

Date of Birth_____

MRN#_____

Account/HAR#_____

PATIENT IDENTIFICATION

Date:_____

Patient Name: _____

Date of Birth: _____ Age: _____

School: _____ Grade: _____ Sport (s): _____

Club: _____ If a gymnast, what level? _____

Referring physician: _____

Drug Allergies? ☐ Y ☐ N _____ Patient lives with: _____
(If yes, what?)

Medical Illnesses? _____ Brothers? _____ Sisters? _____

Previous Surgery? _____ Current Medications? _____

Nutritional Supplements? (creatine, andro, protein, etc): _____

Family History of (please check): ☐ Heart Disease ☐ Neurologic Disease ☐ Cancer ☐ Arthritis
☐ High Blood Pressure ☐ Sudden death before age 40 ☐ Marfans Syndrome
☐ Long QT Syndrome

Medical Information

Yes	No	
☐	☐	Unexplained weight loss or gain?
☐	☐	Recent fever (over 100)?
☐	☐	Eczema, rashes or birth marks?
☐	☐	Eye surgery, glasses or contact lenses?
☐	☐	Heart murmurs, exercise related chest pain or shortness of breath?
☐	☐	Asthma, recurrent cough?
☐	☐	Abdominal pain, vomiting, or constipation?
☐	☐	Kidney, bladder infection, or painful urination?
☐	☐	Joint pain, swelling or fractures?
☐	☐	Concussions, head trauma, seizures?
☐	☐	Problems with thyroid, growth hormone, or diabetes?
☐	☐	Bleeding, easy bruising, low blood count, or sickle cell trait/disease?

If over 14:

☐ ☐ Do you drink alcohol?

Females only:

☐ ☐ Have you started your periods?
If yes, at what age? _____

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Room#: _____

Name of Physician? _____

Which body part(s) did you injure? _____ Left Right

When did you injure it? _____

How did you injure it?

Did it swell? _____ How soon after the injury? _____

How have you been treating it? (ice, heat, elevation, Advil, etc?): _____

How severe is your pain? (mark one)

No pain 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ Worst

Have you ever injured it before? _____ When? _____

How? _____

How was the previous injury treated? _____

What actions make it hurt? (running, sitting, throwing, jumping, tumbling, etc?):

Parent/Guardian Signature: _____ Date _____ Time _____

X-ray use only

2v shoulder R L	2v elbow R L	2v wrist R L
AP Pelvis	AP - frog leg hip R L	2v knee R L
		Notch
		Merchants
3v ankle R L	3v foot R L	2v tib/fib R L
2v - 4v L S Spine	Other: _____	

Provider Signature: _____ Date _____ Time _____

Office Use Only

Dictation Job #:_____

Plan: PT MRI CT Concussion Testing F/U

Assessment: _____

Plan: _____

_____

_____

Provider Signature: _____ Date _____ Time _____

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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:_____