MCSHANE SPORTS MEDICINE
PATIENT INFORMATION

Name _____ Date of Birth _____

Address _____

_____

Phone _____ Cell _____

Occupation _____

Height _____ Weight _____ Male ___ Female ___

Insurance _____

Person Responsible for Account _____

Policy Number _____

Emergency Contact _____ Phone _____

Primary Care Doctor _____

Address _____

Who should we thank for referring you? _____

I authorize payment to MSM for all insurance benefits. I understand that I am financially responsible for all charges not paid by insurance. I authorize MSM to release the information required to secure these benefits.

Signature: _____ Date: _____

McShane Sports Medicine **New Patient Information**

Name_____ **Date of Appointment**_____

Chief Complaint: (Example: Right knee pain, left shoulder pain, etc): _____

_____

History of Present Illness: (How and when did your problem begin? Was there a specific injury?)_____
_____
_____

Please indicate any treatments you have had so far: (Check all that apply)

___None ___Injections ___Physical Therapy (how long and where)_____

___Surgery (where and when) _____

___Medications (for this problem)_____

___Imaging (x-rays or MRI, when and where) _____

Please rate your pain: ___none ___mild ___moderate ___severe

My pain is: (please circle all that apply)

constant intermittent achy burning deep

superficial improving worsening not changing

Modifying factors: (What makes your pain better or worse? Please check all that apply)

___Better or___Worse with activity ___Better or ___Worse with rest

___Better or___Worse with sleep ___Better or___Worse with changing positions ___Nothing

Past Medical History (Please check all that apply): ___**NEGATIVE**

___arthritis ___fibromyalgia ___gout ___hearing loss ___stroke
___coronary disease ___heart attack ____arrhythmia ___asthma ___COPD

___high blood pressure ___GERD ___ulcers ____thyroid disease ___hepatitis

___cancer ___anemia ___diabetes ___colitis ___neuropathy

___excessive bleeding ___DVT (clots) ___osteoporosis ___pulmonary embolism

Past Surgical History (Please check all that apply):___**NEGATIVE**

_____
_____

Do you have any of the following problems? (Please check all that apply) ___**NONE**

___abdominal pain ___constipation/diarrhea ___nausea or vomiting

___balance/dizziness problems ___depression ___pain in multiple joints

___blurred vision ___difficulty with urination ___recent weight gain or loss

___body aches ___headache ___shortness of breath

___hearing loss ___skin bruising/rashes ___swelling in arms or legs

___chest pains or tightness ___heart palpitations ___chronic cough

___chills/fever ___sore or dry throat ___mood swings

Family History (Does anyone in your family have a history of the following?) Please check all that apply:

___arthritis ___stroke ___osteoporosis ___hearing loss ___mult. fractures

___coronary disease ___heart attack ___arrhythmia ____asthma ___substance abuse

___high blood pressure ___GERD ____thyroid disease ___colitis ___pulmonary embolism

___cancer ___anemia ___diabetes ___neuropathy

Social History: (Please check the appropriate space):

Smoking History ___none ___>one pk/day __<one pk/day ___prior smoker who quit…when?____

Alcohol Use ___none ___socially ___daily…How much and what do you drink_____

Recreational Drugs Please list any recreational drug use_____

History of substance abuse? ___No ___Yes. Explain_____

Drug Allergies (Please check or list others): ____**NONE**

__penicillin ___keflex or cephalosporins ___sulfa ___aspirin _____other

Current Medications (**PRINT CLEARLY** and list all medications) ___**NONE**

_____

_____

_____

I authorize my health information to be disclosed to….

My spouse ___yes My children___yes My parents____yes Other_____

_____Signature _____Date