Cone Health Sports Medicine New Patient Intake Form

Name:____________________ DOB:_________________ Date of injury:__________________________________
Today's Date:________________ Phone:_________________ Cell Phone:________________________________
E-Mail Address:____
Occupation and Employer:____

Primary Care Physician:__________________________ Phone Number :_________________________________
How did you hear about our office?____
(Physician,Friend,Wedsite,Relatives,Emergency Department,etc)
What are you here for today?____
How long has this issue been going on?____
Any prior issues with this area before? Yes ____No___;If yes,please describe:______________________________
____
Medical Problems(i.e., Diabetes,High Blood Pressure,etc):____
____
Surgeries:____
____
Medicine Allergies; Yes_____No____;If yes, please list:____
____
Medication List (list only name of medicine(s)-If you have a list, let us know and we will make a copy)
____
____
____

Tobacco Uses: Yes_______ No_____ Quit__;If yes or quit, how many years did or have you smoke(d)___________
About how many packs a day :________ If smokeless,how much: _______________________________________
Alcohol Use: Yes_____ No_____ ; If yes, how much and how often:__________________________________

Family History (please put a check in the boxes that are positive, leave boxes blank all negative)

	Diabetes	High Blood Pressure	High cholesterol	Heart Attack	Stroke	Sudden Death
Mother						
Father						
Siblings						
Child						

Preventative Care (If yes please place approximate date in space below)** Note: Since we are a Prime Care Sports Medicine office, we must adhere to primary care guidelines in chart documentation which includes Preventative care**

	Yes	No	Unsure	Not Applicable	Date
Tetanus (every 10 years)					
Colonoscopy (over 50 years old)					
Flu Shot (yearly)					
Pneumonia Vaccine (over 65 years old)					
Shingles Vaccine (over 60 years old)					
Mammogram (females over 40)					
Pap smear (females)					
PAS (prostate cancer screen)(males0					