

History of Present Illness for Sports Related Injury



A Division of OrthoNJ

Last Name: _____ First Name: _____

Date of Birth: _____ Today's Date: _____

Current Height: _____

Have you had a bone density scan (for osteoporosis)? Yes No

Current Weight: _____

Where/Year: _____

Laterality: Right

Fracture

Left

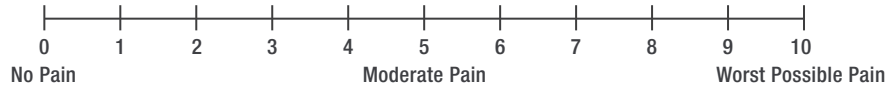
Laceration/Wound

Bilateral

Primary Affected Area: Choose most significant area for today's visit

- Neck Mid Back Low Back Shoulder Clavicle Upper Arm Elbow Forearm
 Wrist Hand Hip Pelvis Thigh Knee Lower Leg Ankle Foot

On a scale of 0 to 10, 0 being no pain and 10 being the worst, please circle below your current level of pain



Signs & Symptoms: Bruising Numbness/tingling Stiffness Weakness Swelling

Aggravated By: Daily Activities Exercise Lifting Overhead Motion Sports Throwing Work

Relieved By: Activity Compression Wrap Elevation Heat Ice Injections NSAIDS Pain Medication
 Physical Therapy Rest Tylenol I do not get relief

Pain Is: Dull Sharp Throbbing Intermittent Constant

Date of Accident: _____

Please explain how the accident occurred: _____

Activity:

- Aerobic/Step Exercise Baseball Basketball Bike Riding
 Bowling Boxing Canoeing Cheerleading Climbing
 Field Hockey Football Golf Gymnastics Hockey
 Lacrosse Exercise Machine Rock Climbing Rowing
 Rugby Running Skateboarding Skiing Soccer
 Softball Other: _____

Place of Accident:

- | | | |
|--|--------------------------------------|---|
| Home | School | Other Location |
| <input type="checkbox"/> Single Family | <input type="checkbox"/> College | <input type="checkbox"/> Recreation Area |
| <input type="checkbox"/> Apartment | <input type="checkbox"/> University | <input type="checkbox"/> Beach |
| <input type="checkbox"/> Dormitory | <input type="checkbox"/> High School | <input type="checkbox"/> Gymnasium |
| | <input type="checkbox"/> Middle | <input type="checkbox"/> Stadium |
| | <input type="checkbox"/> Elementary | <input type="checkbox"/> Public Building |
| | <input type="checkbox"/> Day Care | <input type="checkbox"/> Street |
| | | <input type="checkbox"/> Athletic Court/Field |

Other: _____

Do you have an immediate or previous history of falls? Yes No

Do you use an assistive device to help you ambulate? Yes No

If yes, please check the most appropriate device: Cane Walker Wheelchair Rolling Scooter Other: _____

I certify that the statements provided are true and correct and provided to the best of my ability.

Patient/Guardian's Signature _____

Clinical Staff's Initials _____

Medications You Are Currently Taking



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Today's Date: _____

Patient Name: _____

Date of Birth: _____

List all medications you are taking including non-prescription medications and opioids I am not taking any medications

	Medication #1	Medication #2	Medication #3	Medication #4
Name:				
Dosage:				
Frequency:				
Route:	<input type="checkbox"/> Oral <input type="checkbox"/> Inject <input type="checkbox"/> Topical <input type="checkbox"/> Nasal <input type="checkbox"/> Inhale <input type="checkbox"/> Patch <input type="checkbox"/> Drops	<input type="checkbox"/> Oral <input type="checkbox"/> Inject <input type="checkbox"/> Topical <input type="checkbox"/> Nasal <input type="checkbox"/> Inhale <input type="checkbox"/> Patch <input type="checkbox"/> Drops	<input type="checkbox"/> Oral <input type="checkbox"/> Inject <input type="checkbox"/> Topical <input type="checkbox"/> Nasal <input type="checkbox"/> Inhale <input type="checkbox"/> Patch <input type="checkbox"/> Drops	<input type="checkbox"/> Oral <input type="checkbox"/> Inject <input type="checkbox"/> Topical <input type="checkbox"/> Nasal <input type="checkbox"/> Inhale <input type="checkbox"/> Patch <input type="checkbox"/> Drops
	Medication #5	Medication #6	Medication #7	Medication #8
Name:				
Dosage:				
Frequency:				
Route:	<input type="checkbox"/> Oral <input type="checkbox"/> Inject <input type="checkbox"/> Topical <input type="checkbox"/> Nasal <input type="checkbox"/> Inhale <input type="checkbox"/> Patch <input type="checkbox"/> Drops	<input type="checkbox"/> Oral <input type="checkbox"/> Inject <input type="checkbox"/> Topical <input type="checkbox"/> Nasal <input type="checkbox"/> Inhale <input type="checkbox"/> Patch <input type="checkbox"/> Drops	<input type="checkbox"/> Oral <input type="checkbox"/> Inject <input type="checkbox"/> Topical <input type="checkbox"/> Nasal <input type="checkbox"/> Inhale <input type="checkbox"/> Patch <input type="checkbox"/> Drops	<input type="checkbox"/> Oral <input type="checkbox"/> Inject <input type="checkbox"/> Topical <input type="checkbox"/> Nasal <input type="checkbox"/> Inhale <input type="checkbox"/> Patch <input type="checkbox"/> Drops
	Medication #9	Medication #10	Medication #11	Medication #12
Name:				
Dosage:				
Frequency:				
Route:	<input type="checkbox"/> Oral <input type="checkbox"/> Inject <input type="checkbox"/> Topical <input type="checkbox"/> Nasal <input type="checkbox"/> Inhale <input type="checkbox"/> Patch <input type="checkbox"/> Drops	<input type="checkbox"/> Oral <input type="checkbox"/> Inject <input type="checkbox"/> Topical <input type="checkbox"/> Nasal <input type="checkbox"/> Inhale <input type="checkbox"/> Patch <input type="checkbox"/> Drops	<input type="checkbox"/> Oral <input type="checkbox"/> Inject <input type="checkbox"/> Topical <input type="checkbox"/> Nasal <input type="checkbox"/> Inhale <input type="checkbox"/> Patch <input type="checkbox"/> Drops	<input type="checkbox"/> Oral <input type="checkbox"/> Inject <input type="checkbox"/> Topical <input type="checkbox"/> Nasal <input type="checkbox"/> Inhale <input type="checkbox"/> Patch <input type="checkbox"/> Drops
Preferred Pharmacy:	Name: _____		Address: _____	

Clinical Staff's Initials _____