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, Website, Relative, 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 names of medicine(s)- If you have a list, let us know and we will make a copy)
____
____
____

Tobacco Use: 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 for all negatives)

	Diabetes	High Blood Pressure	High Cholesterol	Heart Attack	Stroke	Sudden Death
Mother						
Father						
Sibling						
Child						

Preventative Care (if yes, please place approximate date in space below)**Note: Since we are a Primary 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)					
PSA (prostate cancer screen)(males)					