MIMA ORTHOPAEDICS & SPORTS MEDICINE QUESTIONNAIRE

Patient Name: ___________________________ Today's Date: _____________ MIMA# _____________

Age: _____________ Gender: Male / Female Hand Dominance: Right / Left

How were you referred to **MIMA Sports Medicine**: ____

Is this appointment related to: workers compensation motor vehicle accident
personal injury with legal representation

Will you be using Health Insurance today? Yes / No Name of Carrier: _________________________

History of Present Illness

Which joint or extremity is primarily bothersome? Right Left ___________________________

What is the primary complaint for which you were referred?

____

____

When did you first experience this problem?

____

____

What seemed to cause the problem? (i.e., gradual onset, overuse, injury)

____

____

____

____

What have you done to treat this problem? (i.e., physical therapy, rest, medication)

____

____

____

____

____

____

 NAME: ____________________________________ MIMA # ___________________

Medical History: Check any below which you have been diagnosed with:

_____ Diabetes	_____ High Blood Pressure	_____ High cholesterol
_____ Thyroid Problem	_____ Pain Management	_____ Gastro-esophageal reflux
_____ Heart Disease	_____ Sleep Apnea	_____ Kidney problems

_____ Other: ____

Current Medications:

Medication	Dosage	Times/Day Taken

Surgical History:

Operation	Year	Doctor	Complications

Allergies: List the names of all medications that you have been diagnosed with allergies:

Medication	Adverse Reaction (eg; rash, hives, shortness of breath)

 NAME: ______________________________ MIMA # ____________________

Personal / Social History:

Do you smoke? Yes No Do you or use tobacco products such as chew? Yes No

If yes, how many packs per day ________ for ________ years.

If you quit smoking, when? ____________

Do you consume alcoholic beverages? Yes No

How often? ____Occasionally ____Weekly ____Daily

How many drinks? _____

Family History: Please check if present in any of your immediate family members:

_____ Breast CA	_____ Uterine CA	_____ Hypertension	____Osteoporosis
_____ Colon CA	_____ Other CA	_____ Heart Disease	
_____ Ovarian CA	_____ Diabetes	_____ Thyroid Disease	

Review of Systems: Please complete the following:

Constitutional:

Fever Y N

Respiratory:

Shortness of Breath Y N

Frequent Cough Y N

Genitourinary:

Painful Urination Y N

Urine Retention Y N

Eyes

Pain Y N

Double Vision Y N

Integumentary

Skin Rash Y N

Persistent Itch Y N

Gastrointestinal

Abdominal Pain Y N

Nausea / Vomiting Y N

Ear/Nose/Throat/Mouth

Ear Infection Y N

Sore Throat Y N

Musculoskeletal

Joint Pain Y N

Cardiovascular

Chest Pain Y N

High Blood Pressure Y N

Allergy/Immunologic

Hay Fever Y N

Comments:

____

____

Patient Signature: ______________________________________ Date: _____________

Physician Signature: ____________________________________ Date: _____________

Update Signature: ____________Date: ______ Update Signature: ____________Date: ________

Update Signature: ____________Date: ______ Update Signature: ____________Date: ________

Update Signature: ____________Date: ______ Update Signature: ____________Date: ________