NATIONWIDE CHILDREN'S
When your child needs a hospital, everything matters.℠

Sports Medicine
New Patient Medical Screening Questionnaire

Please fill out the following questions to the best of your ability.

1. For Parent/ Guardian: What is your relationship to the patient?_____
2. Reason for visit: (Please Circle)
    a. Head injury
    b. Ankle/Foot/Lower Leg - **Right, Left, Both**
    c. Knee - **Right, Left, Both**
    d. Back/Hip/Thigh - **Right, Left, Both**
    e. Shoulder - **Right, Left, Both**
    f. Elbow - **Right, Left, Both**
    g. Hand/Wrist/Fingers- **Right, Left, Both**
    h. Other:_____
3. **Females only:** What is the first day of your last menstrual period?_____
4. Does the patient have any know drug allergies? Please circle: YES or NO
    a. If yes, please list the medication and reaction:_____

    _____
5. Does the patient currently take any medications? YES or NO
    a. If yes, please list:_____

    _____

    *Please include vitamins, minerals or supplements if currently taking.
6. Are immunizations up to date? YES or NO

Turn over ->

7. Does the patient have any current or past medical illnesses or conditions that we need to be made aware of? YES or NO
    a. If yes, please list:_____
8. Has the patient ever had surgery? YES or NO
    a. If yes, please list:_____
9. Does the patient's immediate family have any medical conditions we need to be aware of: YES or NO
    a. If yes, please list: _____

Medical Reconciliation

10. Is the patient receiving breast milk? YES or NO
11. Is the patient currently pregnant? YES or NO
12. Is the patient providing breast milk? YES of NO
13. Did the patient bring any medications with him/her today? YES or NO
14. Is the patient taking any investigational medications? YES or NO

Screening/ Learning

15. Are there any concerns regarding: (Please circle)

    Eating Habits Development Behavioral

16. Are there spiritual/cultural concerns that affect the patient's healthcare? YES or NO
17. Do the patient and/or caregiver have physical or mental learning barriers? YES or NO
18. What is the patient's preferred style of learning? (Please circle)

    Visual Auditory Written