



Children's Hospital of The King's Daughters, Inc
601 Children's Lane, Norfolk, VA 23507-1910

Patient Label or MRN, Acct#, Patient Name, DOB, Date of Service

Children's Specialty Group, PLLC
Division of Sports Medicine
SPORTS MEDICINE
PATIENT QUESTIONNAIRE FORM

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Please answer both sides of this form completely as it relates to the patient.

Referring Physician or Provider _____

Preferred Pharmacy _____

Have any of your siblings or relatives seen Dr. Brenner, Dr. Lamb, Dr. Powell or Dr. Smith? (Please list names & physician) _____

Chief Complaint (what brings you in today?): _____

1. What sports do you participate in? _____

2. Past medical history (any other medical problems?): None

____ Asthma ____ Allergies ____ ADHD/ADD ____ High Blood Pressure
____ Heart Disease ____ Diabetes ____ Migraines ____ Sickle Cell Disease or Trait
____ Depression ____ Anxiety ____ Eating Disorder ____ Other _____

3. Past surgical history (any surgeries in the past?): None

4. Current medications, vitamins or supplements None

5. Drug Allergies

____ None
____ Penicillin
____ Sulfa
____ Other _____

6. What school do you attend? _____ What grade are you in? _____

7. Social History

How many days of the week do you exercise more than 60 minutes? _____

Do you work? ____ Yes ____ No **If yes, Occupation** _____

Do you smoke/vape? ____ Yes ____ No **If yes, how much per day?** _____

Do you drink alcohol? ____ Yes ____ No **If yes, how much per day?** _____

8. Other people you live with: _____

OVER PLEASE

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9. Family history of medical problems:

Father: Yes No
If yes, please explain _____

Mother: Yes No
If yes, please explain _____

Grandparents Yes No
If yes, please explain _____

Siblings (brother/sister) Yes No
If yes, please explain _____

10. Any current problems in the following areas? None If yes, please explain:

___ Fever, weight gain or loss

___ GI problems (stomach)

___ Eyes

___ Bladder

___ Heart circulation

___ Breathing, lungs, shortness of breath

___ Skin

___ Nerves, tremors, coordination, neurological

___ Psychological

___ Endocrine

___ Blood, lymphatics

___ Immune problems

___ Menstrual problems

Other miscellaneous problems _____

Signature of Individual Completing Questionnaire

Relationship to Patient

Date

Reviewed with patient/parent

Physician Signature

Date

Time