

**JAFFE SPORTS MEDICINE & REHABILITATION**  
**NEW PATIENT INFORMATION**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Sex: \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Occupation: \_\_\_\_\_

Referred by: (check one) Self \_\_\_\_\_ Family \_\_\_\_\_ Doctor \_\_\_\_\_ Attorney \_\_\_\_\_

Name of person making referral: \_\_\_\_\_

Who is your primary care physician (family doctor)? \_\_\_\_\_

Reason(s) for visit: \_\_\_\_\_

Circle the studies which you have had to diagnose your injury: MRI Mylogram Bone Scan

X-Ray EMG/NCV CT Scan

Location of test: \_\_\_\_\_

**Any numbness or tingling in the arms/hands/legs/feet?**  Yes  No

If yes, please describe: \_\_\_\_\_

Date symptoms began (approximate): \_\_\_\_\_

Is this problem resulting from a car accident?  Yes  No Work related?  Yes  No

Slip & fall?  Yes  No Litigation involved?  Yes  No

Do you have a history of a car accident/work injury/slip & fall?  Yes  No

If yes, please list the date of injury: \_\_\_\_\_ type of injury: \_\_\_\_\_

Is this injury still problematic?  Yes  No

**Medications:**

Please list medications you are currently taking (include oral contraceptives, aspirin, vitamins/supplements or any over the counter medications):

\_\_\_\_\_  
\_\_\_\_\_

**Drug Allergies:** \_\_\_\_\_

Type of reaction: \_\_\_\_\_

Are you allergic to any foods?  Yes  No If yes, please list: \_\_\_\_\_

**(Please fill out reverse side – Page 2)**

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

Pharmacy name: \_\_\_\_\_ Location: \_\_\_\_\_ Phone: \_\_\_\_\_

Do you prefer your prescriptions to be:  brand name  generic  no preferenceDo you have a past surgical history?  Yes  No If yes, please list your past operations: \_\_\_\_\_**Past Medical History** – Please check if you have any of the following: Heart Disease  High Blood Pressure  Diabetes \_\_\_Insulin Dependent \_\_\_Non-Insulin Dependent Asthma/COPD  Cancer  Seizures  Anemia  Arthritis  Rheumatoid  Osteoarthritis Kidney Disease  Hepatitis/Liver Disease  Headaches  Tuberculosis  Thyroid Disease  Stroke Ulcers  Current Pregnancy  Other illnesses or diseases not listed?  Yes  No If yes, please describe: Psychological Disorder If so, please describe: \_\_\_\_\_**Family Medical History** – Please check if you have any of the following in your family's history: Heart Disease  Cancer  Diabetes  Liver Disease  Chronic Pain  Thyroid Disease  Arthritis Kidney Disease  Lung Disease**Social History**Do you drink alcohol?  Yes  No If yes, how much? \_\_\_\_\_Do you smoke cigarettes?  Yes  No If yes, how much? \_\_\_\_\_Do you use drugs?  Yes  No Recreational? \_\_\_\_\_

Note: This is a confidential record of your medical history and will be kept in this office. Information contained herein will not be released to any person except who you have authorized our office to release to.

To the best of my knowledge, the information on this form has been accurately answered. I understand providing inaccurate information can be dangerous to my (my child's) health. It is my responsibility to inform this office of any changes in my (my child's) medical status. I also authorize the medical staff to perform the necessary health care services that I (my child) may need.

PATIENT/GUARDIAN SIGNATURE: \_\_\_\_\_

I have reviewed this information with this patient. Date: \_\_\_\_\_ Physician Signature: \_\_\_\_\_