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Today's Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Injury: \_\_\_\_\_  
Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Are you:  Left Handed  Right Handed or  Both  
Who is your primary care physician? \_\_\_\_\_ Did they refer you, if not then who? \_\_\_\_\_

1. For what part of the body are you seeking treatment?  Neck  Shoulder (left or right)  Elbow (left or right)  
 Hand (left or right)  Back  Ribs  Hip (left or right)  Knee (left or right)  Ankle (left or right)  Foot (left or right)

2. How did the symptom's begin? \_\_\_\_\_

3. When did the symptom's begin? \_\_\_ days ago \_\_\_ weeks ago \_\_\_ months ago \_\_\_ years ago \_\_\_ unsure

4. Please describe how you were injured: \_\_\_\_\_  
\_\_\_\_\_

5. Choose from the list to describe your symptoms:  Pain  Clicking  Locking  Catching  Swelling  Numbness  
 Tenderness  Bruising  Popping  Deformity  Erythema  Tingling  Warmth  Fever  Giving way  Grinding  
 Snapping  Stiffness  Loss of Motion  Weakness  Mass  Limping  Arch collapse  Calf Pain  Instability  
 Radiating to \_\_\_\_\_

6. How would you describe the symptoms?:  Aching  Burning  Diffuse  Dull  Electric  Sharp  Pounding  Stabbing  
 Tearing  Throbbing  Knifelike  OTHER: \_\_\_\_\_

7. How severe is the pain?  Insignificant  Mild  Moderate  Severe  Marked  
On a scale 1 – 10, with 10 being the worst pain ever and 1 NO pain, how would you rate your pain: \_\_\_\_\_

8. When do you get the symptoms?  Nightly  Daily  Occasional  During activity  after activity  Morning  Daytime  
 End of day  Evening  Night  Rest

9. How have your symptoms gotten?  Improved  Unchanged  Worsened  Details: \_\_\_\_\_

10. What aggravates your symptoms?  Carrying  Grasping  Lifting  Pulling  Pushing  Reaching  Car Driving  
 Recreational Activities  Throwing  Weather changes  Work  Walking  Walking Up Stairs  Walking Down Stairs

11. What therapies have you tried?  Acupuncture  Bedrest  Bracing  Cold packs  Cortisone injections  Elevation  
 Exercise  Hot packs  Night splints  Pain clinic  Physical therapy  Sling  Taping  Warm soaks  Advil  Aleve  
 Tylenol  Glucosamine  Chondroitin  Prescription meds: \_\_\_\_\_

12. How has the therapy changed your symptoms?  Improved  Worsened  No change

13. What are your functional limitations?  Occasional  Often  Constant  Intermittent  Other: \_\_\_\_\_  
If work related, then are you?  Full Duty  Light Duty  Not working

14. Do you do any form of exercise?  YES or  NO. What types? \_\_\_\_\_  
How often? \_\_\_\_\_

**PAST MEDICAL HISTORY:** Do **YOU** have a history of: Please mark all of those for which you have received treatment:

- Migraine Headaches  Ringing in ear  Dizzy Spells  Double or Blurred vision  Sinus trouble  Cataracts  Pneumonia  
 Asthma  High Blood Pressure  Heart Disease  Heartburn/Reflux  Diverticulitis/Crohn's  Urinary Tract Infections  
 Blood in urine  Dialysis  Sex. Trans. Diseases  Weight Loss/Gain  Anemia  Cancer  Diabetes  Seizures  Tremors  
 Osteoarthritis  Rheumatoid Arthritis  Recurrent Back Pain  Fracture  Osteoporosis  Gout/Pseudogout  Depression  
 Agitation  AIDS/HIV  High Cholesterol  Stroke  Hepatitis  Thyroid Disease  Other: \_\_\_\_\_

**PAST SURGICAL HISTORY:** Please list any and all surgical procedures you have had done: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**FAMILY HISTORY:** Please mark any of the following if any blood relative has suffered from the following:

- Epilepsy  Migraine  Mental Illness  Glaucoma  Diabetes  Thyroid Disease  Arthritis  Lupus  Asthma  Anemia  
 Osteoporosis  Stroke  Alcoholism  Hepatitis  Lipid Disorder  Hypertension  Heart Disease  Cancer  
 OTHER: \_\_\_\_\_

**REVIEW OF SYSTEMS:** Please mark those symptoms that you have had any which are associated with what brings you to the office?  NONE

**GENERAL HEALTH:**  EXCELLENT  GOOD  FAIR  POOR

**EYES/EAR/NOSE/THROAT/MOUTH:**  glaucoma  dentures  eyeglass use

**CARDIOVASCULAR:**  Chest pain  shortness of breath  unable to walk one flight of stairs  ankle swelling  fainting

**RESPIRATORY:**  bronchitis  cough **GASTROINTESTINAL:**  Nausea  vomiting  diarrhea  constipation

**GENITOURINARY:**  frequency of urination  burning urination **SKIN AND BREAST:**  psoriasis  infections  keloid's

**FAMILIAL MUSCULAR DISEASES:**  familial skeletal dysplasia's  scoliosis

**NEUROLOGICAL:**  seizures  strokes  weakness  numbness **HEMATOLOGICAL/LYMPHATIC:**  anemia  leukemia

**ALLERGIC/IMMUNOLOGICAL:**  HIV infection  AIDS  LATEX allergy

**SOCIAL HISTORY**

Do you drink alcohol?  None  Socially  Minimal  Moderate; # drinks/day \_\_\_\_\_

Do you smoke cigarettes?  None  Socially  Minimal  Moderate; # packs/day \_\_\_\_\_

Do you use any illicit drugs? \_\_\_\_\_

Highest Level of Education? \_\_\_\_\_ If in school, where and what grade are you in? \_\_\_\_\_

Current Housing Situation (# of stairs): \_\_\_\_\_

**MEDICATIONS:** Please list ALL the medications you currently take: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**ALLERGIES:** \_\_\_\_\_  
\_\_\_\_\_

I, THE PATIENT OR GUARDIAN, CERTIFY THAT ALL THE INFORMATION ON THIS FORM IS TRUE TO THE BEST OF MY KNOWLEDGE..

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

DATE \_\_\_\_\_

PHYSICIAN SIGNATURE \_\_\_\_\_