

Vanderbilt Sports Medicine Multi-Dimensional Health Assessment Questionnaire

1. Patient Demographic Information

Today's Date _____

Patient Name: _____

Social Security number: _____

How many people live at your home with you? _____

Please check (✓) who lives with you

- Spouse/partner Parents Sons or daughters
 I live alone Others (describe) _____
 Brothers/Sisters

At this time are you? (Please check (✓) all that apply)

- Working full time Working part time Retired
 Student Homemaker-full time Disabled
 Other (describe) _____

How many years of school have you completed?

(please circle the number of years of school)
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20

2. How did you hear about the Vanderbilt Sports Medicine Center?

- a. The Phone Book (actual ad in the phone book) g. Personal (family) physician
b. Real Talk (section in the yellow pages with a 4 digit code to call) h. Saw a Vanderbilt Sports Medicine Center Banner
c. Ad in a High School Sports Program i. Saw a Vanderbilt Sports Medicine Center hot air balloon
d. Friend j. Student Health
e. Coach k. Other (please specify) _____
f. Athletic Trainer

3. At which Vanderbilt Sports Medicine Clinic were you seen? a. Nashville b. Murray c. Paducah

4. Educational Needs

Do you have any questions for your healthcare provider about (circle as many as apply)

- (a) Medical condition/diagnosis (b) Medication (c) Activity
(d) Scheduled treatment/procedure/test/surgery (e) Other

5. Nutritional Screen

Have you had any recent changes in your appetite and food intake? Yes No

Have you gained or lost weight recently? Yes No

Are you on a special diet? Yes No If yes, what type _____

Are you having any problems following your diet? Yes No If yes, explain _____

Does lack of money limit your ability to buy food you need? Yes No

* * * * *

For 1 positive response on **Nutrition Screening**, RD referral required. Referral to VUMC RD (936-3952)

Patient refused Reported to Physician (specify) _____

For positive **Educational Screening** (any questions noted), follow up plan: _____

13. In the last month, have you experienced:

Fever	Yes <input type="checkbox"/> No <input type="checkbox"/>	Stomach pain, heartburn or cramps	Yes <input type="checkbox"/> No <input type="checkbox"/>	Losing your balance	Yes <input type="checkbox"/> No <input type="checkbox"/>
Weight Change (10lbs)	Yes <input type="checkbox"/> No <input type="checkbox"/>	Nausea/vomiting	Yes <input type="checkbox"/> No <input type="checkbox"/>	Muscle or joint pain, aches, or cramps	Yes <input type="checkbox"/> No <input type="checkbox"/>
Problems with skin (rash, bleeding, bruising)	Yes <input type="checkbox"/> No <input type="checkbox"/>	Constipation	Yes <input type="checkbox"/> No <input type="checkbox"/>	Swelling of a joint	Yes <input type="checkbox"/> No <input type="checkbox"/>
Problems with ears, nose, throat	Yes <input type="checkbox"/> No <input type="checkbox"/>	Diarrhea	Yes <input type="checkbox"/> No <input type="checkbox"/>	Muscle Weakness	Yes <input type="checkbox"/> No <input type="checkbox"/>
Shortness of breath/wheezing	Yes <input type="checkbox"/> No <input type="checkbox"/>	Dark or bloody stools	Yes <input type="checkbox"/> No <input type="checkbox"/>	Smoking cigarettes	Yes <input type="checkbox"/> No <input type="checkbox"/>
Pain in chest	Yes <input type="checkbox"/> No <input type="checkbox"/>	Problem with urination	Yes <input type="checkbox"/> No <input type="checkbox"/>	More than 2 alcoholic drinks per day	Yes <input type="checkbox"/> No <input type="checkbox"/>
Heart pounding (palpitations)	Yes <input type="checkbox"/> No <input type="checkbox"/>	Gynecological (female) problems	Yes <input type="checkbox"/> No <input type="checkbox"/>	Use of drugs not sold in the stores	Yes <input type="checkbox"/> No <input type="checkbox"/>
Dizziness	Yes <input type="checkbox"/> No <input type="checkbox"/>	Headaches	Yes <input type="checkbox"/> No <input type="checkbox"/>	Eyes/blurred vision	Yes <input type="checkbox"/> No <input type="checkbox"/>

14. Please indicate how often you performed each activity listed below in your healthiest and most active state within the past year.

	<u>Less than one time in a month</u>	<u>One time in a month</u>	<u>One time in a week</u>	<u>2 or 3 times in a week</u>	<u>4 or more times in a week</u>
Running: running while playing a sport or jogging	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cutting: changing directions while running	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decelerating: coming to a quick stop while running	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pivoting: turning you body with your foot planted while playing a sport - for example: skiing, skating, kicking, throwing, hitting a ball (golf, tennis, squash), etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

15. Please list below all operations you have ever had: Please check (✓) here, if none

	<u>Operation</u>	<u>Year</u>	<u>Surgeon</u>	<u>Hospital/City/State</u>
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____

16. Please list below all major illnesses or admissions to a hospital (other than Operations) Please check (✓) if none.

	<u>Illness or reason for hospitalization</u>	<u>Year</u>	<u>Hospital/City/State</u>
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

17. The questions below concern your family medical history:

	<u>AGE(S)</u>	<u>MAJOR MEDICAL CONDITIONS</u>	<u>AGE(S) AT DEATH</u>	<u>CAUSE(S) OF DEATH</u>
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____
Brother(s)	_____	_____	_____	_____
Sister(s)	_____	_____	_____	_____
Son(s)	_____	_____	_____	_____
Daughter(s)	_____	_____	_____	_____

18. Any illnesses which run in the family?

19. Please write below all the drugs or medications you have taken over the past four weeks. (Include aspirin, birth control pills, and any drug or medicine with or without perscription):

<u>NAME OF DRUG OR MEDICINE</u>	<u>DOSE (IF KNOWN)</u>	<u>HOW MANY PER DAY OR WEEK?</u>	<u>NAME OF DRUG OR MEDICINE</u>	<u>DOSE (IF KNOWN)</u>	<u>HOW MANY PER DAY OR WEEK?</u>
1. _____	_____	_____	4. _____	_____	_____
2. _____	_____	_____	5. _____	_____	_____
3. _____	_____	_____	6. _____	_____	_____

(Please list any others on a separate page)

Any of the above drugs cause you side effects? ___ No, ___ Yes. If "Yes", please write the drug(s) and the side effect(s) here:

20. Please list below any medications which you can not take because you are allergic to them:

21. Please list below anything else (grass, molds, pollen, etc.) you might be allergic to:

 Please check if this questionnaire is completed entirely by patient [] or with help from (name) _____

I have reviewed and confirmed this information with the patient: _____, M.D. _____
 Physician Date