Welcome to the UW Health Sports Medicine Clinic

You are scheduled on ___________________________ to see ______________________________.

In order to best serve your needs, please bring with you to your appointment the following:

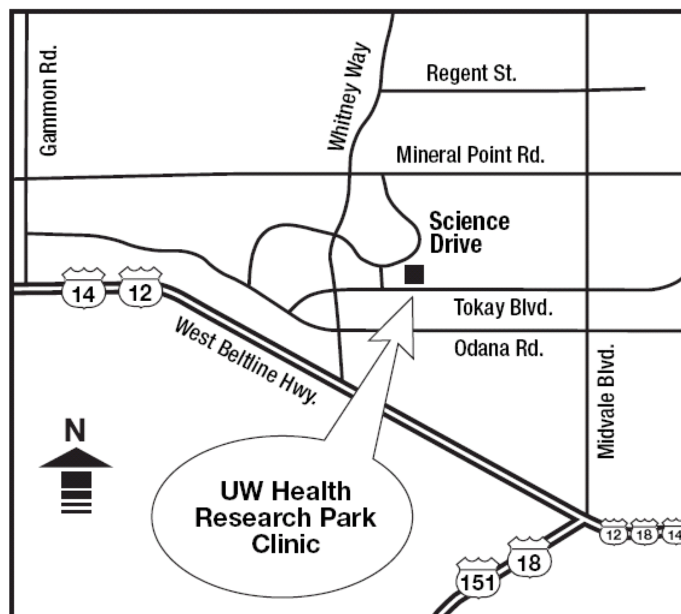
1. **Completed Questionnaire** (enclosed)
2. **Imaging**
   Hand carry any plain x-rays, MRI scans, CT scans, etc. that you may have had done at another facility. Radiology reports are not sufficient; we need the actual film and report. Typically, we require the x-rays to be 1 year old or less. If your insurance will not allow films to be done here, you may want to have new ones done at your clinic.
3. **Medical Records**
   Please bring any previous operative notes.
4. **Insurance Referral** (if needed)
   If you belong to an HMO, bring a copy of your referral with you. If this is a worker's compensation claim, bring the claim number, the name of the insurance company and the address where the claim should be sent.

If you have any questions regarding your upcoming appointment, please do not hesitate to give us a call at (608) 263-8850.

Directions

The Sports Medicine Clinic is located at the UW Health Research Park Clinic, 621 Science Drive, Madison, Wisconsin, 53711. (608) 263-8850 Fax (608) 265-8340.

- From the east – take Mineral Point Road west and turn left on Science Drive (before Whitney Way).
- From the west – take Mineral Point Road east, turn right on Whitney Way and left on Science Drive.
- From the beltline (12&18) – take Whitney Way exit north, go straight through intersections of Odana and Tokay and turn right on Science Drive.



UW Health

uwhealth.org

Welcome to the UW Health Sports Medicine Clinic

To help you better prepare for your clinic visit with us, please review the following information. This comprehensive list outlines what to expect, as well as the health care providers you may encounter at a typical clinic visit. Your visit with us may or may not include all of the services listed below. Thank you again for choosing the UW Health Sports Medicine Clinic as your health care provider.

1. **Check-in and Waiting Area:** Registration/check-in will be as you enter the clinic building. After checking in, proceed to the second floor waiting area. If you are new to our clinic and have not filled out the patient health history questionnaire, please obtain one at the second floor information desk.
2. **Electronic Medical Record Update:** A medical assistant or licensed athletic trainer (MA or LAT) will bring you from the waiting area and take you to your clinic room. The MA or LAT will then update your current medications and health status in your electronic medical record.
3. **Preliminary Examination:** You may first be seen by the physician's resident, physician assistant, nurse practitioner, licensed athletic trainer, or physical therapist, who will note your history, perform a preliminary physical examination, and determine if you need radiographic films.
4. **Radiology:** If you need new x-ray films, you will be sent down the hall to radiology. You may be asked to change into shorts or a gown for x-rays. You will then return to your clinic room. Your films will be sent electronically to your room; you do not need to hand-carry any films.
5. **Physician Evaluation & Assessment:** The physician will review your history and repeat essential parts of the physical examination. At the completion of this assessment, the physician will provide you with a diagnosis and a comprehensive treatment plan.

   This plan may include, but is not limited to, the following:

   - **Prescription for braces/orthotics:** Depending on the type of orthotic prescribed, you may see the orthotic technician at your clinic visit or you may be asked to schedule an appointment at a later date.
   - **Consult for sports rehabilitation:** You may schedule a sports rehabilitation appointment at any provider who is covered by your insurance.
   - **Referral to other health care providers:** Contact information will be provided at your clinic visit. Appointments may be scheduled at the Sports Medicine Clinic check-out desk, or you may be directed to schedule them on your own.
   - **Follow-up appointment:** Proceed to the Sports Medicine Clinic check-out desk to schedule your next appointment. Any doctor orders will have been sent to them electronically.

****Please allow approximately 90 minutes for your initial clinic visit.****

Welcome to our clinic

Welcome!

Welcome to our clinic. Thank you for the opportunity to be a partner in your health care. At UW Health we strive to provide the best possible care. Our clinic is part of the University of Wisconsin. In addition to your physician, nurse practitioner or physician assistant, you may be seen by a resident physician, medical student, athletic trainer or advanced practice nursing student.

Telephone Availability

Feel free to call any time you have concerns about your health. If you call the clinic before 4 p.m. we will make every effort to respond that day. If your call is urgent, we will review your needs and arrange for care.

To respect your privacy, we will not leave information on answering machines or share information regarding patients over the age of 18 without their permission.

After Hours Care

In the event of an emergency, call 911. For urgent questions or concerns, please call (608) 262-2122. You will be connected to the answering service. They will contact the physician on call. Our doctors admit patients to UW Hospital.

Prescriptions

Before you run out of a prescribed medication, you can renew as follows:
1. Ask your doctor during your appointment.
2. Call your pharmacy, who will contact your doctor for you.

Please contact your pharmacy at least 48 hours before your medication runs out.

Lab Work/Tests

You will be contacted with your test results within 14 days unless your doctor tells you otherwise. If you have not received your test results after two weeks, please call the clinic at (608) 263-8850.

Appointments - Outpatient Attendance

Please schedule your return appointment before leaving. If you have questions or concerns before your next scheduled appointment, don't hesitate to call the clinic. If you have changes in your medication, allergies or current health, please share with your provider at your next scheduled appointment. If you need to cancel an appointment, please call us as soon as possible. This allows us to meet the needs of other patients.

Please contact our registration department at (608) 262-1400 with any changes of address or insurance. We require verification of information through registration every 120 days. Contacting our registration department before your appointment will prevent delays.

Resources

Question/ Concern	Resource	Contact Information
Insurance	Please call your insurance company to verify coverage for therapy services.	
Billing	Patient Billing Service	(608) 262-2221 or (866) 841-8535
Pricing	Priceline	(608) 263-1507
Financial Hardship	Community Care Line	(608) 262-2221 or (866) 841-8535
Other Questions	Patient Relations	(608) 263-8009
On-Line prescription renewal	Pharmacy	uwhealth.org/rx

UW Health
University of Wisconsin Sports Medicine
uwsportsmedicine.org

621 Science Drive
(608) 263-8850

5-Hole 1/4 1 3/8 c-to-c

Patient Name:

DOB:

MR #:

University of Wisconsin Hospital and Clinics
621 Science Drive • Madison, Wisconsin 53711

PATIENT HEALTH QUESTIONNAIRE

Date:___________________________________

Age: __________ Height:_________in/cm Weight:_____________lbs/kg

Primary Care Physician: ________________________________Referring Physician: ___________________________________

MAIN CONCERN / CHIEF COMPLAINT

What problem can we help you with today? ____
Have you already been given a diagnosis? Yes___ No___
If yes, what was the diagnosis?____

HISTORY OF PRESENT ILLNESS

What was the date of injury? Or How long have you had this problem?____
Rate your pain on a scale of 0 to 10 (0=no pain, 10= worst pain you ever had)

Today: 0 1 2 3 4 5 6 7 8 9 10
At its worst: 0 1 2 3 4 5 6 7 8 9 10

Please rate the level to which you feel the following activities are affected by your current problem.
(0 = no effect, 10 = unable to perform)

Sports: 0 1 2 3 4 5 6 7 8 9 10
Work: 0 1 2 3 4 5 6 7 8 9 10
Sleep: 0 1 2 3 4 5 6 7 8 9 10
Daily activities: 0 1 2 3 4 5 6 7 8 9 10

Would you describe your pain as: (Check all that apply)
___constant ___on/off ___sharp ___dull ___achy
___burning ___pressure ___tingling/electrical

Do you have any of the following associated symptoms (Check all that apply):
___muscle weakness ___loss of range of motion ___locking/catching
___feeling of giving way/dislocation ___tenderness to touch
___limp ___swelling ___numbness/tingling

What else have you tried for treatment and/or pain control? Circle Y/N to indicate if these were helpful.
___Rest Y/N ___Ice Y/N ___Ibuprofen (advil/motrin)Y/N ___Aspirin Y/N ___Tylenol Y/N
___Aleve (naproxen) Y/N ___Splint/brace Y/N ___Physical therapy Y/N
___Other (please list) ____ Y/N

What makes your pain worse? ____

Since your diagnosis/injury, check the activities that are painful/difficult:
___moving in bed ___positional changes ___turning/twisting ___sitting
___standing ___shopping/banking ___yard work ___meal prep
___housekeeping ___driving/car riding

Has any other medical provider seen you for this problem? Yes___ No___
Have you had an x-ray for this problem? Yes___ No___
Have you had an MRI or Ultrasound for this problem? Yes___ No___
Have you had an EMG for this problem? Yes___ No___
Where were these performed? ____

Patient Name:

DOB:

MR #:

REVIEW OF SYSTEMS

Please circle any of the symptoms you are currently experiencing.

General
Weight Loss
Fevers/Chills
Fatigue
Gastrointestinal
Heartburn
Nausea/Vomiting
Abdominal Pain
Liver problems
Cardiovascular
Chest pain
Palpitations
Respiratory
Cough / short of breath

Genitourinary
Kidney problems
Painful urination
Skin
Skin Rash / redness
Skin wound
Neurological
Headaches
Dizziness
Psychosocial
Depression
Anxiety
Sleep Disturbance

Ears/Nose/Throat
Hearing loss
Hoarseness
Congestion
Hematologic
Easy bleeding
Easy bruising
HIV/AIDS
Endocrine
Diabetes
Thyroid problems
Eyes
Vision Problems

PAST SURGICAL HISTORY

Have you had previous surgeries? If yes, what?

1. Right Left Body Part: ______________________ Surgeon: ______________________ Year: ________
2. Right Left Body Part: ______________________ Surgeon: ______________________ Year: ________

PAST MEDICAL HISTORY

Do you have or have you ever had any of the following?

__ High blood pressure
__ Heart disease/Heart attack
__ Heart/Bypass surgery
__ Angioplasty
__ Blood clots
__ Diabetes
__ Kidney disease

__ Asthma
__ COPD/Emphysema
__ Tuberculosis
__ Seasonal allergies
__ Stomach ulcers
__ Acid reflux/heart burn
__ Rheumatoid arthritis/Lupus/Autoimmune disease (circle)

__ Arthritis
__ Cancer
__ Hepatitis
__ Migraine headaches
__ Stroke

FAMILY HISTORY

Do any of your close relatives have any bone or joint problems? Yes___ No___

If yes, what problems do they have? ______________________

SOCIAL HISTORY

Do you smoke? Yes___ No___ How many packs/day?___ How long? ___ years

Do you drink alcohol? Yes___ No___ How many drinks per week?___

What is your occupation? ______________________

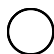
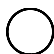
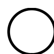
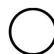
Are you currently working? Yes___ No___ If yes, are you on light duty? Yes___ No___

Is this a Workers Compensation injury? Yes___ No___

Completed by:______________________Date:____________

If not completed by patient, relationship to patient:______________________

Reviewed by:______________________ Date:____________Time:__________

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