NYU Langone MEDICAL CENTER

HARKNESS CENTER for Dance Injuries

HARKNESS CENTER FOR DANCE INJURIES' PATIENT MEDICAL HISTORY FORM

Date: ________ / ________ / ________

Name: ____

Date of Birth: _______ / _______ / _______

Sex: ☐M ☐F

Race: ☐ African-American ☐ Asian ☐ Caucasian

☐ Hispanic ☐ Other: __________

Orthopedic History:

CHECK any orthopedic injury you have had and describe below.
ALSO CIRCLE any injury that caused you to completely stop dance activity, meaning class, rehearsal or performance for two or more days.

☐Ankle / Foot:
- ☐ arthritis
- ☐ impingement
- ☐ os trigonum
- ☐ sesamoiditis
- ☐ stress fracture
- ☐ other________________
- ☐ fracture
- ☐ morton's neuroma
- ☐ plantar fasciitis
- ☐ sprain
- ☐ tendinitis

☐Lower Leg / Shin:
- ☐ compartment syndrome
- ☐ myositis
- ☐ stress fracture
- ☐ fracture
- ☐ shin splints
- ☐ other________________

☐Knee:
- ☐ arthritis
- ☐ bursitis
- ☐ chondromalacia
- ☐ iliotibial band syndrome
- ☐ ligament sprain/rupture (ACL, medial collateral)
- ☐other________________
- ☐ osgood-schlatter's
- ☐ osteochondritis dissecans
- ☐ patellar dislocation
- ☐ patella femoral syndrome
- ☐ patellar tendinitis
- ☐ torn meniscus

☐Thigh:
- ☐ femur fracture
- ☐ muscle strain / tear
- ☐ stress fracture
- ☐ other_______________

☐Hip / Pelvis:
- ☐ arthritis
- ☐ bursitis
- ☐ dislocation
- ☐ fracture
- ☐ growth plate injury
- ☐ other _______________
- ☐ hip flexor strain
- ☐ labral tear
- ☐ osteitis pubis
- ☐ snapping hip
- ☐ stress fracture

☐Lumbar-Sacral Spine (low back):
- ☐ arthritis
- ☐ disc herniation/protrusion
- ☐ facet syndrome
- ☐ fracture
- ☐ pinched nerve
- ☐ sacroiliac sprain / dysfunction
- ☐ other _______________
- ☐ sciatica
- ☐ scoliosis
- ☐ spinal stenosis
- ☐ spondylolysis
- ☐ spondylolisthesis

☐Cervical / Thoracic Spine (neck / mid back)/Ribs:
- ☐ arthritis
- ☐ disc herniation/protrusion
- ☐ facet syndrome
- ☐ fracture
- ☐ pinched nerve
- ☐ scoliosis
- ☐ spinal stenosis
- ☐ spondylolisthesis
- ☐ spondylolysis
- ☐ thoracic outlet syndrome
- ☐ whiplash
- ☐ other _______________

☐Shoulder:
- ☐ acromioclavicular joint sprain/separation
- ☐ arthritis
- ☐ bursitis
- ☐ dislocation/subluxation
- ☐ fracture
- ☐ other_______________
- ☐ impingement
- ☐ labral tear
- ☐ mechanical instability
- ☐ rotator cuff tear
- ☐ scapulo-thoracic dyskinesis
- ☐ tendinitis

☐Elbow / Wrist / Hand:
- ☐ arthritis
- ☐ carpal tunnel syndrome
- ☐ dislocation
- ☐ fracture
- ☐ osteochondritis (bone chip in joint)
- ☐ sprain
- ☐ tendinitis
- ☐ torn cartilage
- ☐ ulnar neuritis
- ☐ other _______________

Give dates and explain treatments for any items checked from the above.____

____

☐ Yes ☐ No Have any of the above injuries required x-rays, MRI, CT scan, injections, physical/occupational therapy, a brace, a cast, or crutches?
If yes, please state which injuries and tests and give dates:

____

☐ Yes ☐ No Do any of the above injuries still bother you?
If yes, describe:

Medical History: Check below any medical conditions that you have been diagnosed with:

☐ Anemia
☐ Asthma
☐ Atlantoaxial instability
☐ Concussion; loss of consciousness
☐ Connective tissue/ rheumatologic disease
☐ Depression
☐ Diabetes
☐ Difficulty controlling bowel
☐ Difficulty controlling bladder
☐ Easy bleeding
☐ Heart infection/Endocarditis
☐ Thyroid disease/ hormonal imbalance
☐ Enlarged spleen
☐ Heart murmur
☐ Hepatitis
☐ Herpes or MRSA infection
☐ High blood pressure
☐ High cholesterol
☐ Kawasaki disease
☐ Mono (infectious mononucleosis)
☐ Osteopenia or osteoporosis
☐ Numbness, tingling, or weakness in arms

Did you have to stop dancing because of any medical conditions you checked in the medical history boxes at left? ☐ Yes ☐ No

Give dates and treatments for any of the checked items:
____
____

Which, if any, of the checked conditions are ongoing?
____
____
____

☐ Yes ☐ No Have you ever been hospitalized?
If so, describe and give date(s):____

____

☐ Yes ☐ No Have you ever had surgery?
If so, describe and give date(s):____

____

Do you take any medications or supplements?
☐ Prescription medication ☐ Herbal supplement/tea ☐ Over-the-counter medication (non-prescription, e.g. Advil)
☐ Calcium supplements ☐ Daily vitamin ☐ Other
If so, please list ____

Do you have any allergies?
☐ Medication ☐ Stinging insects ☐ Food ☐ Environmental ☐ Other
If so, please list all allergies and reaction to allergen(s): ____

Family History:

Has anyone in your family been diagnosed with a medical condition?

☐ Arthritis
☐ Diabetes
☐ Cancer
☐ Heart problem
☐ High blood pressure
☐ Osteoporosis
☐ Pacemaker/implanted defibrillator
☐ Psychological
☐ Seizure
☐ Stroke
☐ Unexplained fainting
☐ Other______________

Give details for any items to the left checked:
____
____
____

Has any family member died of heart problems or had an unexplained sudden death before age 50? ☐ Yes ☐ No

General Health:

Please rate your health: ☐ Excellent ☐Good ☐Fair ☐Poor

What is your height and weight? _______Feet _______Inches _______Pounds

☐ Yes ☐ No Do you currently smoke tobacco? If so, how many cigarettes/cigars per day? ________

How many alcoholic drinks do you have per week on average? (one beer/glass of wine equals one drink) _________

☐ Yes ☐ No Have you ever felt you need to cut down on your drinking?

Are you on a special diet or do you avoid certain types of foods? ☐ Vegetarian ☐ Vegan ☐ Other ______________

☐ Yes ☐ No Do you worry about your weight? If you are not satisfied with your weight, what is your ideal weight? ____ lbs

Has anyone recommended that you gain or lose weight?
☐ Dance teacher/director ☐ Family member ☐ Doctor/medical professional ☐ Peer
☐ No one has recommended weight change ☐ Other_________________

☐ Yes ☐ No Does your weight often fluctuate by more than 10 lbs?

☐ Yes ☐ No Have you ever had an eating disorder?

Are you interested in nutritional counseling? ☐ Yes ☐ No

On a typical day, how many hours do you sleep? __________ hours
☐ Yes ☐ No Do you feel that this amount is *not* adequate for you?
☐ Yes ☐ No Do you have difficulty falling asleep, difficulty staying awake in the daytime, have loud snoring/gasping to breathe when asleep or have trouble with nightmares or epic dreams?

☐ Yes ☐ No Have you had any major life changes during the past year?
☐ Yes ☐ No Do you feel stressed out or under a lot of pressure?
Over the past two weeks, how often have you lost interest or pleasure in doing things?
☐ Not at all ☐ Several Days ☐ More than half the days ☐ Nearly every day
Over the past two weeks, how often have you been feeling down, depressed, or hopeless?
☐ Not at all ☐ Several Days ☐ More than half the days ☐ Nearly every day

☐ Yes ☐ No Do you have any changes in bowel or bladder function (i.e. increased frequency or control)?
☐ Yes ☐ No Do you have any sensation changes in your genitalia (the area which would come in contact with a bicycle seat)

Women**:**
Age of first menstrual period: _______
☐ Yes ☐ No Is your menstrual period *irr*egular (does not occur every 28-35 days)?
If yes, what is the time period between cycles (days)? ________
☐ Yes ☐ No Has your menstrual period been *irr*egular in the past?
If yes, at what age did the irregular pattern exist? ______________
How long did the irregular pattern exist? _______________
What was the length between cycles? __________________
☐ Yes ☐ No Do you use a form of birth control that gives you estrogen supplementation?

Dance History:

Which of the following best describes you?
☐ Choreographer ☐ Professional-track dance student ☐ Professional dancer ☐ Recreational dancer
☐ Teacher ☐ Retired ☐ Other_______________

What is your primary type of dance?
☐ Ballet ☐ Modern ☐ Musical Theater ☐ Jazz ☐ Hip-hop ☐ African
☐ Tap ☐ Ballroom ☐ Other ________________

Name of Primary Dance School or Company: ____

Number of years of professional dancing: ___________
At what age did you begin serious dance training? __________
If pointe, at what age did you begin pointe work? ___________

How many hours of class do you take in a typical week? ☐0 ☐1-5 ☐6-10 ☐11-15 ☐16-20 ☐>20
How many hours do you rehearse and perform in a typical week? ☐0 ☐1-5 ☐6-10 ☐11-15 ☐16-20 ☐>20
How many hours per day do you typically train en pointe? ☐0 ☐1-5 ☐6-10 ☐11-15 ☐16-20 ☐>20

Do you warm up? ☐ Never ☐ Seldom ☐ About half the time ☐ Usually ☐Always
If so, what does your warm up consist of? ____

Do you stretch? ☐ Never ☐ Seldom ☐ About half the time ☐ Usually ☐Always
When do you stretch? ☐ Before dance ☐ During dance ☐ After dance
How do you stretch? ☐ Static (prolonged holds) ☐ Dynamic (through movement) ☐ Ballistic (bounding)

If you do any cardiovascular or strengthening exercise outside of your warm up on a regular basis, please describe:
____
How many days per week? _______ For how long per session on average (in minutes)? _______

Type of dance shoe(s) worn most often for dance:
☐ None ☐ Ballet slippers ☐ Character shoes ☐ Jazz oxfords ☐ Pointe Shoes
☐ Sneakers ☐ Street shoes ☐ Other________

Do you dance on sprung floor (resilient)? ☐ Never ☐ Seldom ☐ About half the time ☐ Usually ☐Always

☐ Yes ☐ No Do you have another job to subsidize your dance life?
If yes, how many hours do you work per week?_____________
If yes, what are the physical demands of your job?____

<u>CURRENT Medical Complaint</u>:

Part of body: ____ Development of Injury: ☐Traumatic / Acute ☐Slow Onset

Rate your current level of pain (circle one. 0 = no pain; 10 = unbearable pain):
0 1 2 3 4 5 6 7 8 9 10

Date of injury, inability to participate in full dance, or "trigger" (the day you decided to seek care for a slow onset injury):

______/______/______; ☐ Morning ☐ Afternoon ☐Evening

If you have had this injury before, when did this injury first occur? ____
☐Dance ☐Non-dance Was this a dance or a non-dance-related injury?

What did you do for the problem(s)? ____
☐Yes ☐No Did the problem(s) get better?

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Today's Date: _________

Patient Name: _______________________ ID#: _____________ DOB: __________________ Sex: M/F

What was the mechanism of injury?
☐Inversion ☐Eversion ☐Hyperextension ☐Hyperflexion ☐Rotation ☐Compression ☐Valgus ☐Varus ☐Repetitive Stress ☐Other_____

Body Part: ☐Left ☐ Right

☐Trunk/Back
- ☐Cervical
- ☐Thoracic
- ☐Lumbar /Sacral
- ☐Pelvis

☐Lower Extremity
- ☐Hip/Pelvis
- ☐Thigh
- ☐Knee
- ☐Leg
- ☐Foot/Ankle

☐Upper Extremity
- ☐Shoulder
- ☐Elbow
- ☐Arm/Forearm
- ☐Wrist/Hand
- ☐Head

Injury Type
- ☐Acute/sub-acute (<6 wks)
- ☐Chronic (> 6wks)
- ☐Chronic Recurrent
- ☐Post-operative

DIAGNOSIS ☐ Preliminary ☐ Final

Muscle/Tendon Injury
- ☐Contusion
- ☐Mechanical LBP
- ☐Metatarsalgia
- ☐Plantar Fasciitis
- ☐Tendinopathy/Bursitis
  - ☐Achilles
  - ☐Biceps brachii
  - ☐Calcific
  - ☐FHL
  - ☐Greater Trochanteric
  - ☐ ITB
  - ☐Lateral Epicondylitis
  - ☐Medial Epicondylitis
  - ☐Olecranon process
  - ☐ Patellar
  - ☐ Peroneal
  - ☐ Pes Anserine
  - ☐Psoas/Iliopsoas
  - ☐Quadriceps
  - ☐Rotator Cuff
  - ☐Tibialis Anterior
  - ☐Tibialis Posterior
  - ☐Other_________
- ☐Strain
  - ☐Grade I
  - ☐Grade II
  - ☐Grade III / Rupture
  - Tissue:
    - ☐Quadriceps
    - ☐Hamstring
    - ☐Adductor
    - ☐ITB
    - ☐Gastroc
    - ☐Soleus
    - ☐Abdominals
    - ☐Other________
- ☐Other_________________

Internal Derangement/ Joint Capsule
- ☐Capsulitis
- ☐Capsular Strain
- ☐Cuboid Syndrome
- ☐Cyst
  - ☐Ganglion
  - ☐Meniscal
- ☐Dislocation/Subluxation
- ☐Failure Orthopedic Implant
- ☐Hallux Valgus
- ☐Hernia
- ☐HNP
- ☐Impingement
  - ☐Anterior
  - ☐Posterior
- ☐Joint Contracture
- ☐Labral Tear
- ☐LMT
- ☐Loose Bodies
- ☐Mechanical Instability
- ☐MMT
- ☐Morton's Neuroma
- ☐Patellofemoral Syndrome
- ☐Plica Syndrome
- ☐Sciatica
- ☐SI Joint Disorder
- ☐Synovitis
- ☐Other_______

Fracture/Bony Injury
- ☐Apophysitis
  - ☐Sever's Disease
  - ☐Osgood-Schlatter's
- ☐Avascular Necrosis
- ☐Bone Spur
- ☐Chondromalacia
- ☐D.J.D.
- ☐Fracture
  - ☐ Dancer's (5th met)
  - ☐Jones Fracture
  - ☐Metatarsal
  - ☐Stress Fracture
    - ☐Calcaneus
    - ☐Femur
    - ☐Fibula
    - ☐ Metatarsal
    - ☐Pelvis
    - ☐ Spondylolysis
    - ☐Talus
    - ☐Tibia
    - ☐Other________
- ☐Hallux Limitus
- ☐Osteochondral injury
- ☐Os trigonum syndrome
- ☐Osteoarthritis
- ☐Osteoporosis
- ☐Periostiitis
- ☐Scoliosis
- ☐Sesamoiditis
- ☐Spondylolisthesis
- ☐Other ____________

Ligament Injury
- ☐Sprain
  - ☐Grade I
  - ☐Grade II
  - ☐Grade III / Rupture
  - Tissue:
    - ☐AC Joint
    - ☐ACL
    - ☐Forefoot
    - ☐LCL
    - ☐Lateral Ankle
    - ☐MCL
    - ☐Midfoot
    - ☐PCL
    - ☐Syndesmosis
    - ☐1st MTP Jt
    - ☐Other______

Misc
- ☐Concussion
- ☐Laceration
- ☐ Benign Tumor

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Patient Name: _______________________ ID#: _____________ DOB: __________________ Sex: M/F

MD Recommendations:

☐Modify Dance Activity ☐Full Dance Activities ☐No Dance Activities

☐Surgery

☐Diagnostic Testing

- ☐X-ray
- ☐MRI/MRA
- ☐Bone Scan
- ☐CT Scan
- ☐Lab Work
- ☐Other____________

Date: _______________________________

Time Lost

(Injury caused the dancer to completely stop dance activity, meaning class, rehearsal or performance outside of DOI itself.)

☐Yes

☐No

Date of return to any amount of dance______________________

 # days lost______________________

Referrals or Outside Recommendations

- ☐ PCP
- ☐ Nutritionist/Dietician
- ☐ Psychologist
- ☐ Podiatrist
- ☐ Oncologist
- ☐ Cardiologist
- ☐ Sleep Specialist
- ☐ Other_____________

NOTES:____

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