



DBNJ Sports Medicine Specialists

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Social History: (Circle) _____

Smoking	Sometimes	Moderate	Heavy	None	___ppd * ___yrs
Alcohol	Sometimes	Moderate	Heavy	None	
Exercise	Sometimes	Moderate	Heavy	None	
Occupation:	_____				
Sports:	_____				

Immediate Family History (Circle)

Heart Disease / High Blood Pressure / Diabetes / Kidney Disease / Arthritis / Cancer

Father: _____ Brother: _____
 Mother: _____ Sister: _____

Review of Systems Evaluation: (Have you experienced the following over the last 3 months)

General:

Weight Changes
 Fever, Chills, Night Sweats
 Excessive Fatigue

Cardiac

Chest Pain
 Arrhythmia
 Palpitations
 Murmur
 Leg Swelling

Lungs:

Shortness of breath
 Cough, sputum, blood
 Wheezing

Gastrointestinal

Abdominal pain
 Nausea / Vomiting
 Constipation / Diarrhea
 Black / Bloody Stool
 Heartburn

Neurology

Headaches
 Dizziness
 Passing Out
 Numbness / Tingling
 Excessive weakness

Endocrine

heat/cold intolerance
 excessive thirst/urination
 Elevated blood sugars
 Hair / Skin changes

Hematologic

easy bruising or bleeding
 swollen lymph nodes

Genitourinary

frequent urination
 painful urination
 urinary retention
 blood in the urine

Ear / Nose / Throat

Sinus Pressure
 Nose Bleeding
 Sore throat

Dermatology:

unexplained rashes
 sores or wounds

Psychiatric

Anxiety
 Depression

Musculoskeletal

joint swelling / stiffness / pain
 muscle pain / weakness
 neck / shoulder / arm / hand pain
 leg / knee / ankle / foot pain
 locking, catching, instability
 painful clicking

Other Problems: _____

Females: LMP: ___/___/___

Menstrual Flow: Regular / Irregular Days of Flow _____ Cycle Length _____