

New Jersey Sports Medicine and Performance Center  
598 Somerset Street, North Plainfield, NJ 07060

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

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Date of Injury or Onset of Symptoms: \_\_\_\_\_

Briefly Describe Present Symptoms:    RIGHT    LEFT    \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

What makes your pain better? \_\_\_\_\_

What makes your pain worse? \_\_\_\_\_

Have you had similar symptoms before?    Yes    No    When? \_\_\_\_\_

List X-ray, MRI, or studies that have been done (DATE and LOCATION):

\_\_\_\_\_

List Physicians that have treated you for these symptoms:

\_\_\_\_\_

Did a health care provider recommend that you see us (NAME and ADDRESS)?

\_\_\_\_\_

Does this involve:    Motor Vehicle Accident    Liability    Workman's Compensation

**Medications/Vitamins/Supplements:**    NONE

\_\_\_\_\_

**Allergies to any medications, latex, injections etc:**    NONE

\_\_\_\_\_

**Past Medical History:**    NONE

\_\_\_\_\_

**Previous Surgeries:**    NONE

\_\_\_\_\_

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**Social History:**

Smoking	Occasional	Moderate	Heavy	None	Quit ____ years ago
Alcohol	Occasional	Moderate	Heavy	None	
Substance Use	Occasional	Moderate	Heavy	None	
Exercise	Occasional	Moderate	Heavy	None	
Sleep	Restful	Non-restful	Poor		
Occupation:	_____				

**Family History:**

Heart Disease      Stroke      Cancer      Diabetes      Arthritis      Osteoporosis

Other: \_\_\_\_\_

**Review of Systems (Are you currently experiencing any of the following):**

<b>General Health</b> fatigue fever, sweats, chills recent weight change	<b>Brain/Nerves</b> headache dizziness blackouts	<b>Blood/Lymphatic</b> anemia swollen lymph node bleeding/bruising	<b>Bone/Joint/muscle</b> joint swelling joint warmth joint stiffness muscle pain back pain arm pain leg pain weakness
<b>Lungs (Respiratory)</b> short of breath cough wheeze	numbness/tingling tremor/shaking weakness memory loss	<b>Endocrine/Metabolic</b> elevated blood sugar excessive thirst excessive urination heat/cold intolerance hair loss/skin changes	
<b>Heart/Vascular</b> chest pain irregular heart beat leg swelling leg cramping	<b>Vision</b> change in vision visual disturbances	<b>Gastrointestinal</b> diarrhea constipation change in bowel habit abdominal pain abdominal bloating bloody/black stools nausea/vomiting	<b>Other problems:</b> _____ _____ _____
<b>Ear/nose/throat</b> frequent infections allergy/hay fever sinus problems	<b>Skin/Dermatology</b> rash sores/wounds itching		
<b>Psychiatric</b> feeling anxious feeling depressed suicidal counseling	<b>Urinary/genital</b> frequent urination nighttime urination blood in urine painful urination leaking urine discharge		

**FEMALES:**

Pregnant: Yes No      Planning: Yes No

Menstrual Flow: Regular every month      Irregular      Days of flow \_\_\_\_\_ Length of cycle \_\_\_\_\_

Date of last menstrual period \_\_\_\_\_

Date of last pap \_\_\_\_\_      Normal      Abnormal

Date of last mammogram \_\_\_\_\_      Normal      Abnormal

Do you want to lose weight? Yes No      Are you on a diet? Yes No

History of eating disorders? Yes No