Cyd Charisse Williams, M.D,
Dr. Katrina Thompson-Bowdry, D.C,
Mara Gardner, MHS/PT, LMT, NCTMB

NAME:
DOB:
DATE:

Athletics SPORTS MEDICINE, LLC

REVIEW OF SYSTEMS

In order to offer you the best care, we need to understand your general health status. Please answer the following by checking the boxes as indicated:

C-CURRENT Currently has this condition.
P-PREVIOUSLY Had the condition in the past but does not have any problem now.
N-NEVER Never had the condition.

C	P	N		
			GENERAL	
			Fever	
			Chills	
			Night sweats	
			Loss of sleep	
			Fatigue	
			Nervousness	
			Weight loss/gain	
			Allergies	
			Bleeding problem	
			Anemia	
			Diabetes	
			Cancer	
			Thyroid disease/goiter	
			Alcoholism	
			Drug abuse	
			EAR,EYE,NOSE,THROAT	
			Poor vision	
			Eye pain	
			Hearing problems	
			Nosebleeds	
			Nose problems	
			Sinus trouble	
			Dental problems	
			Hoarseness	
			Tonsillectomy	
			RESPIRATORY	
			Difficulty breathing	
			Shortness of breath	
			Chronic cough	
			Spitting phlegm	
			Coughing/spitting up blood	
			Wheezing/asthma	
			Pneumonia	
			Tuberculosis	
			EXERCISE	
			None	
			1-2 times a week	
			3-4 times a week	
			6-7 times a week	

C	P	N		
			CARDIOVASCULAR	
			Irregular heart beat	
			High blood pressure	
			Chest pain	
			Heart problem	
			Ankle swelling	
			Varicose veins	
			Rheumatic fever	
			Stroke	
			SKIN	
			Itching	
			Bruising easily	
			Change in mole(s)	
			Skin cancer	
			Hair/nail change(s)	
			Scar(s)	
			GASTROINTESTINAL	
			Poor appetite	
			Poor digestion	
			Difficulty swallowing	
			Belching/gas	
			Frequent nausea	
			Vomiting blood	
			Pain over abdomen	
			Stomach ulcer	
			Black/bloody stool	
			Liver problems	
			Gallbladder problems	
			Jaundice	
			Diarrhea	
			Constipation	
			Bloating	
			Hemorrhoids	
			Appendicitis	
			Hernia	
			MEN ONLY	
			Prostrate problems	
			Testicular problems	
			Breast lump/pain	
			Stress Fracture	

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REVIEW OF SYSTEMS CONT.

C-CURRENT Currently has this condition.
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WOMEN ONLY

C	P	N		
☐	☐	☐	Painful periods	
☐	☐	☐	Excessive flow	
☐	☐	☐	Irregular cycles	
☐	☐	☐	Vaginal bleeding/itching	
☐	☐	☐	Hot flashes	
☐	☐	☐	Cramping	
☐	☐	☐	Birth control pills	
☐	☐	☐	Breast lump/pain	
☐	☐	☐	Stress fractures	
			Date of last cycle?	
			First menstrual cycle?	
			Days cycle lasts?	
			Days between cycles?	
			How many periods in the past 12 months?	
			What helps your cramps?	
			Last pelvic exam?	
			Last breast exam?	

GENITOURINARY

☐	☐	☐	Frequent urination	
☐	☐	☐	Painful urination	
☐	☐	☐	Blood in urine	
☐	☐	☐	Urinary tract infection	
☐	☐	☐	Kidney disease	
☐	☐	☐	Kid stones	
☐	☐	☐	Inability to control urination	
☐	☐	☐	Difficulty starting urination	
☐	☐	☐	Get up at night to urinate	
☐	☐	☐	STD	
☐	☐	☐	HIV/AIDS	
☐	☐	☐	Sexual difficulties	

NEUROLOGIC

C	P	N		
☐	☐	☐	Weakness	
☐	☐	☐	Twitching	
☐	☐	☐	Tremor	
☐	☐	☐	Headache	
☐	☐	☐	FaintingDizziness	
☐	☐	☐	Convulsion	
☐	☐	☐	Epilepsy/Seizures	
☐	☐	☐	Numbing/tingling	
☐	☐	☐	Arm/leg pain	
☐	☐	☐	Depression	
☐	☐	☐	Bipolar	
☐	☐	☐	Schizophrenia	
☐	☐	☐	Obsession/Compulsive	
☐	☐	☐	Opposition Defiant	
☐	☐	☐	Anxiety	

FILL OUT BELOW IF FOLLOW UP VISIT

MEDICATIONS/ SUPPLEMENTS

1
2
3
4
5
6

☐ REVIEWED

FAMILY HISTORY

Changes in Family History?
YES NO

☐ REVIEWED

IF FOLLOW UP VISIT AND HAVE NEW CONCERNS PLEASE LIST BELOW.

EX: On June 13, 2013 I felt a pop in my right knee playing soccer during a bicycle kick. It feels unstable to walk on and knee is swelling.

☐ REVIEWED