PERFORMANCE MEDICINE
OF SOUTHWEST VIRGINIA, LLC
SPORTS MEDICINE
FAMILY MEDICINE • SLEEP MEDICINE

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NAME:____ DOB____/_____/_____ DATE: ____/____/_____

CHIEF COMPLAINT (WHY YOU ARE SEEING DR BOLIN): "________________________________ ". DOI:____/____/______

SLEEP HISTORY:

What is your worst symptom? _________________________ How long have you had it?_________________________________

Describe how it started: ____

What time do you usually go to bed? _______________ How long till you fall asleep?__________ _____

What time do you usually wake up? ___________ ____

What meds have you tried for this? ____

Have you been told you snore?___________________ Have you been told you stop breathing when you sleep? ________________

Do you wake with a dry mouth? ___________________ Do you wake up with morning headaches? ____________________________

Have you had a sleep study previously (when)? ____

Were you given a diagnosis (What diagnosis, what doctore, when approximately? ____

Was CPAP or orther intervention suggested? ____

Who else have you seen for this problem? ____

SURGERIES: (What/when/who/where): ____
________________________________ ____

MEDICATIONS: (PLEASE LIST NAME & DOSAGE)

1.____________________________________
2.____________________________________
3.____________________________________
4.____________________________________
5.____________________________________
6.____________________________________
7.____________________________________

ALLERGIES TO MEDICINE & YOUR REACTION:

____
____

SOCIAL HISTORY:

Occupation?____________________ Employer______________________________

Married Y • N; Smoking Y • N If yes, how many packs/day & how long?
____packs/day; _____years

How many Caffeinated drinks do you drink in a given day? ___________________

FAMILY HISTORY:

Mom: (Medical Problems; if deceased – what from?
____

Dad: (Medical Problems; if deceased – what from)
____

Brothers/ Sisters?____

Any sleep– related conditions run in your family?_____________________________

REVIEW OF SYSTEMS: Circle any that apply : Do you have?

GENERAL: Fever • chills • night sweats • weight gain • weight loss • pain at night
HEENT: Vision change • difficulty with hearing • difficulty swallowing
HEART: Chest pain • heart murmur • atrial fibrillation • dizzy spells • hypertension • rapid pulse • palpitations
PULMONARY: Shortness of breath • asthma • cough •
GASTROINTESTINAL: Stomach Ulcers • Acid Reflux GERD • Constipation • diarrhea • blood in stool • incontinence • IBS • Crohns
GENITO-URINARY: Problems urinating • kidney stones • incontinence of urine
(for men): prostate problems • difficult erections • (for women) irregular periods • vaginal discharge
MUSCULOSKETAL: Joint pain • swelling • morning stiffness • diagnosed with arthritis of any body part
NEURO: Back pain worse w/cough/sneeze • history of disc disease • numbness in hands/feet • weakness • loss of motion • problems with balance • loss of bowel or bladder control •
ENDOCRINE: Diabetes • thyroid problems • adrenal **PSYCHIATRIC:** Depression • Bipolar
HEMATOLOGIC: anemic • bleeding problems • easy bruising or bleeding
SKIN: rashes • skin cancer • IF you have reviewed and have none of these, initial here:________________