

Patient Name: _____

REVIEW OF SYSTEMS

Chart#: _____

Have you had a prior problem with this same Orthopedic condition in the past? N Y (explain below)

Do your other joints have: morning stiffness lasting over 30 minutes joint pain or swelling Back Pain Gout
 Rheumatoid arthritis Osteoporosis prior fracture (which bone) _____ None of these

Have you had any of these symptoms? If no, mark None.

				NONE	YEAR	Details/Comments
1) GI	<input type="checkbox"/> Heartburn, ulcers	<input type="checkbox"/> Nausea, Vomiting	<input type="checkbox"/> Blood in Stool	<input type="checkbox"/>	_____	_____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____
	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Liver disease				
2) ENDO	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Heat or Cold Intolerance		<input type="checkbox"/>	_____	
3) CON	<input type="checkbox"/> Weight Loss	<input type="checkbox"/> Loss of Appetite		<input type="checkbox"/>	_____	
4) EYE	<input type="checkbox"/> Blurred Vision	<input type="checkbox"/> Double Vision	<input type="checkbox"/> Vision Loss	<input type="checkbox"/>	_____	
5) ENT	<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Hoarseness	<input type="checkbox"/> Trouble Swallowing	<input type="checkbox"/>	_____	
6) CV	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Palpitations		<input type="checkbox"/>	_____	
7) RS	<input type="checkbox"/> Chronic Cough	<input type="checkbox"/> Shortness of Breath		<input type="checkbox"/>	_____	
8) GU	<input type="checkbox"/> Painful Urination	<input type="checkbox"/> Blood in Urine	<input type="checkbox"/> Kidney problems	<input type="checkbox"/>	_____	
9) SK	<input type="checkbox"/> Frequent Rashes	<input type="checkbox"/> Skin Ulcers	<input type="checkbox"/> Lumps <input type="checkbox"/> Psoriasis	<input type="checkbox"/>	_____	
10) NEU	<input type="checkbox"/> Headaches	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Seizures	<input type="checkbox"/>	_____	
11) PSY	<input type="checkbox"/> Depression	<input type="checkbox"/> Drug/Alcohol Addiction	<input type="checkbox"/> Sleep disorder	<input type="checkbox"/>	_____	
12) HEM	<input type="checkbox"/> Easy Bleeding	<input type="checkbox"/> Easy Bruising	<input type="checkbox"/> Anemia	<input type="checkbox"/>	_____	
13) ARE YOU HIV POSITIVE:				<input type="checkbox"/> N <input type="checkbox"/> Y		

PAST MEDICAL HISTORY

Are you Diabetic? N Y If Yes, treatment: Insulin Oral Meds Diet None

Are you taking, or have you ever taken, blood thinners? N Y If yes, which one? _____

Past Surgical History: What operations have you had and when? Please list: _____

Have you or a family member ever had a reaction to anesthesia? N Y EXPLAIN: _____

Past Hospitalizations: (Not for Surgery): _____ None

Have you ever had: Heart attack (year _____) High Blood Pressure Blood Clots (year _____) Stroke Heart Failure

Ankle Swelling Kidney failure Cancer (location _____)

Stomachache while taking anti-inflammatories (includes Advil/Aleve) What anti-inflammatories have you already had a problem with? _____

I do not have any of the above conditions.

FAMILY HISTORY: Have any direct relatives had any of the following disorders? If so, which relative?

Diabetes _____ High Blood Pressure _____ Rheumatoid Arthritis _____ NONE

Do any direct relatives have the same condition you are being seen for today? Y N

SOCIAL HISTORY:

Do you use tobacco? N Y If Yes, packs per day _____ Patient informed of Smoking Risk? Y

Alcohol use? N Y If yes, how often? Daily Other _____/week

Marital History: M S D W How many people live with you? _____

Occupation: _____ Student

Employer: _____

Do you plan to be working 6 months from now? Y N

PLEASE SIGN: The information on these this form is accurate to the best of my knowledge.

Signature _____ Date _____

FOR OFFICE USE ONLY

Completed _____ Date _____

Review #1 by _____ MD Date: _____ Review #2 by _____ MD Date: _____