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**	☐ Heartburn, ulcers	☐ Nausea, Vomiting	☐ Blood in Stool	☐	____	
	☐ Hepatitis	☐ Liver disease				
2) **ENDO**	☐ Thyroid Disease	☐ Heat or Cold Intolerance		☐	____	
3) **CON**	☐ Weight Loss	☐ Loss of Appetite		☐	____	
4) **EYE**	☐ Blurred Vision	☐ Double Vision	☐ Vision Loss	☐	____	
5) **ENT**	☐ Hearing Loss	☐ Hoarseness	☐ Trouble Swallowing	☐	____	
6) **CV**	☐ Chest Pain	☐ Palpitations		☐	____	
7) **RS**	☐ Chronic Cough	☐ Shortness of Breath		☐	____	
8) **GU**	☐ Painful Urination	☐ Blood in Urine	☐ Kidney problems	☐	____	
9) **SK**	☐ Frequent Rashes	☐ Skin Ulcers	☐ Lumps ☐ Psoriasis	☐	____	
10) **NEU**	☐ Headaches	☐ Dizziness	☐ Seizures	☐	____	
11) **PSY**	☐ Depression	☐ Drug/Alcohol Addiction	☐ Sleep disorder	☐	____	
12) **HEM**	☐ Easy Bleeding	☐ Easy Bruising	☐ Anemia	☐	____	

13) **ARE YOU HIV POSITIVE:** ☐ N ☐ 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:_____