



ARLINGTON ORTHOPEDIC ASSOCIATES, P.A.

REVIEW OF SYSTEMS FORM

Name: _____ Age: _____ Date: _____

Dr.(s) requesting consultation: _____

List of all Dr.(s) you see: _____

Ht: _____ Wt: _____ Are you **allergic to any medications?** Yes _____ No _____

Please list them: _____

Are you currently taking any medications? Yes _____ No _____

<u>Current Medication(s)</u>	<u>Dosage</u>	<u>How many times per day</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list any surgery you've had & approximate dates: _____

Past Hospitalizations & dates other than listed above: _____

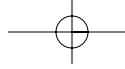
Have you ever had, or do you now have any of the following? If yes, please list the dates (such as: diabetes since 1979 or stroke in May, 1990) and give other important information

	Yes	No	Comments		Yes	No	Comments
Diabetes	___	___	_____	Lung Disease	___	___	_____
Thyroid Disease	___	___	_____	Asthma	___	___	_____
High Blood Pressure	___	___	_____	Emphysema	___	___	_____
Heart Disease	___	___	_____	Tuberculosis	___	___	_____
Heart Attack	___	___	_____	Shortness of Breath	___	___	_____
Bypass Surgery	___	___	_____	Sleep Apnea	___	___	_____
Congestive Failure	___	___	_____	Stomach Problems	___	___	_____
Irregular Heartbeat	___	___	_____	Ulcers	___	___	_____
Chest Pain	___	___	_____	Stomach Pain	___	___	_____
Liver Disease	___	___	_____	Bowel Changes or Problems	___	___	_____
Hepatitis	___	___	_____	Arthritis	___	___	_____
Yellow Jaundice	___	___	_____	Muscle Weakness	___	___	_____

FOR PHYSICIAN USE ONLY

DATE	INITIALS	DATE	INITIALS

(OVER)



PATIENT SIGNATURE

Do you drink alcohol? Never Rarely Moderate Daily How much? _____
 If yes, how much and for how long? _____
 Have you ever smoked? Yes No When? _____
 What are your hobbies / interests? _____
 If retired, please list previous occupation(s) _____
 Current Occupation: _____
 Marital Status: (circle one) Single Married Widowed Separated Divorced

Do you have family history of:
 Diabetes: Yes No
 Stroke or Heart Attack: Yes No
 Arthritis: Yes No
 Cancer: Yes No
 Anesthesia Problems: Yes No
 Other: _____

Please list any disorder or medical conditions which you have or have had in the past which have not been noted above. Include any history of fractures, dislocations and other orthopedic problems: _____

Neurologic Problems	Yes	No	Comments
Stroke	_____	_____	_____
Paralysis	_____	_____	_____
Numbness or Tingling	_____	_____	_____
Headache	_____	_____	_____
Kidney Problems	_____	_____	_____
Stones	_____	_____	_____
Failure	_____	_____	_____
Trouble Urinating	_____	_____	_____
Skin Problems	_____	_____	_____
Rash	_____	_____	_____
Changes in Skin Color	_____	_____	_____
Anemia	_____	_____	_____
Bleeding Trouble	_____	_____	_____
Blood Transfusion	_____	_____	_____
Trouble Hearing	_____	_____	_____
Dizziness / Vertigo	_____	_____	_____
Ringling in Ears	_____	_____	_____
Cancer	_____	_____	_____
Infectious Disease	_____	_____	_____
Organ Transplant	_____	_____	_____
Mental Illness	_____	_____	_____
HIV / AIDS	_____	_____	_____

