



ARLINGTON ORTHOPEDIC ASSOCIATES, P.A.

REVIEW OF SYSTEMS FORM

Name: _____ Age: _____ Date: _____

Are you allergic to any medications? yes _____ no _____

If yes, please list them _____

Are you currently taking any medications: yes _____ no _____

If yes, please list them _____

Please list any surgeries that you have had

Have you ever been hospitalized other than for the above? _____

Past Medical History

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

ROS

Diabetes _____ yes _____ no _____

Thyroid disease _____ yes _____ no _____

High blood pressure _____ yes _____ no _____

Heart disease _____ yes _____ no _____

Heart attack _____ yes _____ no _____

Bypass surgery _____ yes _____ no _____

Congestive Failure _____ yes _____ no _____

Irregular beat _____ yes _____ no _____

Chest pain _____ yes _____ no _____

Lung disease _____ yes _____ no _____

Asthma _____ yes _____ no _____

Emphysema _____ yes _____ no _____

Tuberculosis _____ yes _____ no _____

Shortness of breath _____ yes _____ no _____

Stomach problems _____ yes _____ no _____

Ulcers _____ yes _____ no _____

Stomach pain _____ yes _____ no _____

Liver disease _____ yes _____ no _____

Hepatitis _____ yes _____ no _____

Yellow jaundice _____ yes _____ no _____

Bowel changes or problems _____ yes _____ no _____

Arthritis _____ yes _____ no _____

Muscle weakness _____ yes _____ no _____

Endo

Cardiovascular

Respiratory

Gastrointestinal

(See second page below)

Neurologic problems _____	yes _____	no _____	_____	Neurologic
Stroke _____	yes _____	no _____	_____	
Paralysis _____	yes _____	no _____	_____	
Numbness or tingling _____	yes _____	no _____	_____	
Headache _____	yes _____	no _____	_____	Genitourinary
Kidney Problems _____	yes _____	no _____	_____	
Stones _____	yes _____	no _____	_____	
Failure _____	yes _____	no _____	_____	
Trouble urinating _____	yes _____	no _____	_____	S k i n
Skin problems _____	yes _____	no _____	_____	
Rash _____	yes _____	no _____	_____	
Changes in skin color _____	yes _____	no _____	_____	Hem
Anemia _____	yes _____	no _____	_____	
Bleeding trouble _____	yes _____	no _____	_____	
Blood transfusion _____	yes _____	no _____	_____	ENT
Trouble hearing _____	yes _____	no _____	_____	
Dizziness/vertigo _____	yes _____	no _____	_____	
Ringing in ears _____	yes _____	no _____	_____	Const
Cancer _____	yes _____	no _____	_____	
Infectious disease _____	yes _____	no _____	_____	
Organ transplant _____	yes _____	no _____	_____	Mental illness
Mental illness _____	yes _____	no _____	_____	

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. _____

Do you have a family history of.

Diabetes	yes _____	no _____	Cancer	yes _____	no _____
Stroke or Heart attack	yes _____	no _____	Anesthesia problems	yes _____	no _____
Arthritis	yes _____	no _____	Other:	_____	

Marital status: (circle one) single married widowed

Current Occupation: _____

If retired, please list previous occupation(s) _____

What are your hobbies/interests? _____

Have you ever smoked? yes _____ no _____ quit _____ (when? _____)

If yes, how much and for how long? _____

Do you drink alcohol? yes _____ no _____

If yes, how much in a typical day? _____

Your e-mail address will be used as your legal signature if submitted electronically.