Foundation Foot & Ankle - REVIEW OF SYSTEMS FORM

Revised 5/2018

PATIENT'S NAME:____________________________________ **DATE OF BIRTH:**______________

Reason for today's visit: ____

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Please indicate either Yes or No for ALL questions:

Cardiovascular	**Yes**	**No**
Heart attack	___	___
Valve replacement	___	___
High blood pressure	___	___
High cholesterol	___	___
Pacemaker / defibrillator	___	___
Swelling of feet	___	___
Respiratory		
Asthma or wheezing	___	___
Emphysema / COPD	___	___
Gastrointestinal		
Cirrhosis	___	___
Hepatitis	___	___
Stomach ulcer	___	___
Genitourinary		
Dialysis	___	___
Renal (kidney) disease	___	___
Musculoskeletal		
Back pain	___	___
Osteoarthritis	___	___
Fibromyalgia	___	___
Gout	___	___
Osteoporosis	___	___
Rheumatoid arthritis	___	___
Psychiatric		
Chemical dependency	___	___
Dementia / Alzheimer's	___	___

Neurological	**Yes**	**No**
Cerebral palsy	___	___
Multiple sclerosis	___	___
Numbness or tingling	___	___
Paralysis	___	___
Polio	___	___
Seizures	___	___
Stroke	___	___
Endocrine		
Type1 Juvenile diabetes	___	___
Type2 adult onset diabetes	___	___
Do you take insulin?	___	___
Hematologic / Lymphatic		
Bleeding disorders	___	___
Blood clots / DVT / PE	___	___
History of MRSA infection	___	___
Cancer (type:______________)	___	___
Radiation treatment	___	___
Chemotherapy	___	___
Skin		
Psoriasis	___	___
Rash / itching	___	___

X____ ______________________

Patient / Legal representative / Parent signature Date (Physician's signature) Date