PERSONS
ORTHOPAEDIC SPORTS MEDICINE & JOINT REPLACEMENT CENTER

REVIEW OF SYSTEMS: Do you have now, or have you ever had, any of the following health problems?

1) **M/S** • Have you had a prior problem with this same Orthopaedic condition in the past? ❑ Y ❑ N (explain below)

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2) Have you had **prior** ❑ Back Pain ❑ Joint Swelling ❑ Prior Fracture ❑ Arthritis ____________

3) **ARE YOU A DIABETIC?** ❑ **Y** ❑ **N** TREATMENT: ❑ Insulin ❑ Oral Meds ❑ Diet ❑ None

	(Please check any that apply, or mark None)	**None**	**Year**	**Explain Details/Comments**
4) **CON**	❑ Weight Loss ❑ Loss of Appetite ❑ Fever ❑ Cancer	❑	____	____________
5) **EYE**	❑ Glasses ❑ Contacts ❑ Double Vision ❑ Cataract	❑	____	____________
6) **ENT**	❑ Hearing Loss ❑ Hoarseness ❑ Ringing in Ears	❑	____	____________
7) **CV**	❑ High Blood pressure ❑ Heart Attack ❑ Blood Clots	❑	____	____________
8) **RS**	❑ Asthma ❑ Cough ❑ Pneumonia ❑ Short of Breath ❑ TB	❑	____	____________
9) **GI**	❑ Stomach Ulcer ❑ Hepatitis ❑ Blood in Stool	❑	____	____________
10) **GU**	❑ Pain with Urination ❑ Blood in Urine ❑ Kidney Disease	❑	____	____________
11) **SK**	❑ Skin Ulcers ❑ Rash ❑ Lumps	❑	____	____________
12) **NEU**	❑ Seizures ❑ Stroke ❑ Balance Problem ❑ Headaches	❑	____	____________
13) **PSY**	❑ Depression ❑ Nervousness ❑ Sleep Disorder	❑	____	____________
14) **HEM**	❑ Easy Bleeding ❑ Easy Bruising ❑ Anemia	❑	____	____________

PAST MEDICAL HISTORY

★ **PAST HOSPITALIZATIONS (Not for surgery)** ❑ None ____________________

PAST SURGICAL HISTORY: What operations have you had? When? ❑ None ____________________

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Have you ever had a reaction to anesthesia? ❑ **Y** ❑ **N**

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

★ Any direct relative with the same Orthopaedic condition you are being seen for today? ❑ Y ❑ N ____________

Diabetes ❑ Y ❑ N ____ High Blood Pressure ❑ Y ❑ N ____ Heart disease ❑ Y ❑ N ____ Arthritis ❑ Y ❑ N ____

SOCIAL HISTORY:

★ Do you use tobacco? ❑ Y ❑ N Packs per day ___ Alcohol use? ❑ Y ❑ N How often? ❑ Daily ❑ Other____/week

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

Occupation: ____________________ ❑ Student Employer:____________________

Are you currently working? ❑ Y ❑ N If no, how long have you been off work? ____________________

______________________________ ______________________________

Signature Date

This is an authorization for treatment.

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