ADVANCED ORTHOPEDICS

Name:_____ Today's Date:_____

Review of Systems: Are you experiencing any of the following now?

Constitutional

Weight Loss:	Yes	No
Weight Gain:	Yes	No
Fever:	Yes	No

Eyes

Glasses/Contacts:	Yes	No
Blurred /Double Vision:	Yes	No
Eye Disease:	Yes	No

Ears/Nose/Throat

Hearing Difficulty:	Yes	No
Nose Bleeds:	Yes	No
Ear Infections:	Yes	No

Cardiovascular

Chest Pain:	Yes	No
High Blood Pressure:	Yes	No
Heart Murmur:	Yes	No

Respiratory

Shortness of Breath:	Yes	No
Chronic Cough:	Yes	No
Asthma:	Yes	No
Emphysema:	Yes	No

Genitourinary

Frequent Urination:	Yes	No
Blood in Urine:	Yes	No
STD:	Yes	No

Endocrine

Diabetes:	Yes	No
Hypothyroid:	Yes	No

Skin

Rashes:	Yes	No
Redness:	Yes	No
Itching:	Yes	No

Neurologic

Headaches:	Yes	No
Seizures:	Yes	No
Numbness/Tingling:	Yes	No

Psychiatric

Depression:	Yes	No
Memory Loss:	Yes	No
Confusion:	Yes	No

Hematologic

Hepatitis:	Yes	No
Jaundice:	Yes	No
Blood Clots:	Yes	No

Musculoskeletal

Painful Joints:	Yes	No
Muscle Spasms:	Yes	No
Swelling of Joints:	Yes	No
Morning Stiffness:	Yes	No

Gastrointestinal

Nausea/Vomiting:	Yes	No
Abdominal Pain:	Yes	No
Stomach Ulcers:	Yes	No