

**RECONSTRUCTIVE ORTHOPAEDICS & SPORTS MEDICINE, INC.**

**Review of Systems / Past Personal, Family and Social History**

*Please fill this form out completely*

Name \_\_\_\_\_ Date \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

Family Physician: \_\_\_\_\_ Who recommended you to our office? \_\_\_\_\_

**Please List Current Medications and Dosage:**

_____	_____	_____
_____	_____	_____
_____	_____	_____

**Allergies:** [ ] Medications \_\_\_\_\_ [ ] Other Food, IVP, Latex, Adhesive) \_\_\_\_\_

**Do you have, or have you had any of the following conditions?** [ ] No [ ] Yes (Please circle )

- |                          |                       |                       |                                 |
|--------------------------|-----------------------|-----------------------|---------------------------------|
| Ulcers                   | Tuberculosis          | Rheumatoid Arthritis  | Pulmonary Embolism              |
| Heart Attack             | Phlebitis /Blood Clot | Kidney Problems       | Respiratory Problem             |
| High Blood Pressure      | Diabetes              | Hypothyroid           | Asthma / Emphysema / Bronchitis |
| Irregular Heart Beat     | Cancer                | Hyperthyroid          | Stroke                          |
| Congestive Heart Failure | Sickle Cell Disease   | Hepatitis / Jaundice  | Seizure                         |
| Circulatory Problems     | Multiple Myeloma      | Neurological Disorder | Drug / Alcohol Dependency       |

**Please List Any Other Serious Illness or Injury:** \_\_\_\_\_

**Have you or any member of your family ever had a reaction to anesthesia?** \_\_\_\_\_

**Previous Operations:** (Type and Date)

_____	_____
_____	_____

**Do You Smoke Cigarettes /Cigars?** [ ] Yes [ ] No Amount \_\_\_\_\_

**Do You Drink Alcohol?** [ ] Yes [ ] No Amount \_\_\_\_\_

**Do You Exercise?** [ ] Yes [ ] No Type \_\_\_\_\_

**Current Work Status:** [ ] Working [ ] Light Duty [ ] Part-time [ ] Off work [ ] Retired [ ] Disabled [ ] N/A

If off-work, is this due to current problem? [ ] Yes [ ] No Other employment \_\_\_\_\_  
 Current Employer \_\_\_\_\_ Position Held \_\_\_\_\_

**Do You Have A Family History Of Any Of The Following Conditions?** [ ] No [ ] Yes. If Yes, Please List Family Member Relationship.

Cancer and Type _____	Stroke _____	Diabetes _____
Hypertension _____	Rheumatoid Arthritis _____	Bleeding Problem _____
	Heart Disease _____	

**ROS: Do You Have Any Of The Following Symptoms?**

	Yes	No		Yes	No		Yes	No
<b>Constitution:</b> Fever			<b>Resp:</b> Shortness of breath			<b>Neuro:</b> Convulsions/Seizures		
Wt. Loss _____ lbs.			Persistent cough			Numbness		
Wt. Gain _____ lbs.								
<b>Eyes:</b> Blurred or double vision			Coughing up blood			<b>MS:</b> Muscle weakness		
<b>ENT:</b> Problems swallowing			Wheezing			Deformity of legs, feet, arms, back		
Hearing loss			<b>GI:</b> Heartburn			Joint swelling		
<b>CV:</b> Chest pain			Nausea			Joint pain or stiffness		
Racing heartbeat			Vomiting			<b>Skin:</b> Rash		
<b>Endocrine:</b> Increased thirst			Diarrhea			Lesions		
Increased urine output			<b>Psych:</b> Depression			Itching		

Patient \_\_\_\_\_ Date \_\_\_\_\_ Check-in \_\_\_\_\_ OrthTech \_\_\_\_\_