



Makefield Orthopaedics, PC

PATIENT NAME _____ Date _____

NOTE: THIS IS A CONFIDENTIAL RECORD AND WILL BE KEPT IN YOUR DOCTOR'S OFFICE. INFORMATION CONTAINED HERE WILL NOT BE RELEASED TO ANYONE WITHOUT YOUR AUTHORIZATION TO DO SO.

REVIEW OF SYSTEMS

Do you have or are you currently experiencing any of the following? If so, please circle YES.

Constitutional Symptoms:

Fevers Yes
Weakness Yes
Weight Loss Yes
Night Sweats Yes
Weight Gain Yes

Cardiovascular:

CHF (Congestive Heart Failure) Yes
CAD (Coronary Artery Disease) Yes
MI (Heart Attack) Yes
MVP (Mitral Valve Prolapse) Yes
CABG (Coronary Artery Bypass) Yes
HTN (High Blood Pressure) Yes
Hypotension (low blood pressure) Yes
PVD (Peripheral Vascular Disease) Yes

Gastrointestinal:

History of Peptic Ulcer Yes
Blood in Stools Yes
Heartburn/Reflux Yes

Psychiatric:

Depression Yes
Antidepressant drug use Yes

Hematologic/Lymphatic:

History of blood transfusion Yes
Bleeding or bruising tendency Yes
Anemia Yes
Lymphoma/Leukemia Yes
Deep Vein Thrombosis (DVT) Yes
Pulmonary Embolism (PE) Yes

Integumentary (Breast/Skin)

Skin Infection Yes
Rashes Yes
Breast Cancer Yes
Psoriasis Yes

Respiratory

Pneumonia Yes
Asthma Yes
COPD Yes

Genitourinary:

Urethral discharge Yes
Frequent urination Yes
Urinary urgency Yes
Female-post menopausal Yes
BPH Yes
Prostate Cancer Yes

Neurological:

Multiple Sclerosis Yes
Paralysis Yes
Stroke Yes
Headaches Yes
Numbness/Tingling of Extremities Yes
Seizures/Convulsions Yes
Frequent Falls Yes
Dizziness Yes

Endocrine:

Osteoporosis Yes
Hypothyroid (under active) Yes
Hyperthyroid (over active) Yes
Diabetes Yes
Insulin Dependent Diabetes Yes

Allergic/Immunologic:

Latex Yes
Skin Sensitivity Yes
HIV Yes

Musculoskeletal:

Neck Pain Yes
Osteoarthritis Yes
Rheumatoid Arthritis Yes
Gout Yes
Pseudogout Yes
Back Pain Yes
Joint pain or stiffness Yes
Muscle weakness Yes

OTHER SIGNIFICANT ILLNESS OR DISEASES: _____