

Review Of Systems



Patient Name

Account #

Date

Please circle yes or no if you are **currently** having any of the following:

CONSTITUTIONAL SYMPTOMS

| | | |
|--------------------------------|-----|----|
| Are you in good general health | YES | NO |
| Recent weight change | YES | NO |
| Fever | YES | NO |
| Fatigue | YES | NO |
| Headaches | YES | NO |

MUSCULOSKELETAL

| | | |
|-------------------------------|-----|----|
| Joint pain | YES | NO |
| Joint stiffness or swelling | YES | NO |
| Weakness of muscles or joints | YES | NO |
| Muscle pain or cramps | YES | NO |
| Back pain | YES | NO |

CARDIOVASCULAR

| | | |
|---------------------------------|-----|----|
| Heart trouble | YES | NO |
| Chest pain or angina pectoris | YES | NO |
| Palpitation | YES | NO |
| Shortness of breath | YES | NO |
| Swelling of feet, ankles, hands | YES | NO |

INTEGUMENTARY

| | | |
|----------------------|-----|----|
| Rash or itching | YES | NO |
| Change in skin color | YES | NO |
| Varicose veins | YES | NO |

RESPIRATORY

| | | |
|----------------------------|-----|----|
| Chronic or frequent coughs | YES | NO |
| Spitting up blood | YES | NO |
| Asthma | YES | NO |

ENDOCRINE

| | | |
|-------------------------------|-----|----|
| Glandular or hormone problem | YES | NO |
| Thyroid disease | YES | NO |
| Excessive thirst or urination | YES | NO |
| Heat or cold intolerance | YES | NO |
| Skin becoming dryer | YES | NO |

GASTROINTESTINAL

| | | |
|-----------------------------------|-----|----|
| Loss of appetite | YES | NO |
| Change/pain in bowel movements | YES | NO |
| Nausea or vomiting | YES | NO |
| Frequent diarrhea | YES | NO |
| Constipation | YES | NO |
| Rectal bleeding or blood in stool | YES | NO |
| Abdominal pain or heartburn | YES | NO |

HEMATOLOGICAL/LYMPHATIC

| | | |
|-------------------------------|-----|----|
| Slow to heal after cuts | YES | NO |
| Bleeding or bruising tendency | YES | NO |
| Anemia | YES | NO |
| Phlebitis | YES | NO |
| Past transfusions | YES | NO |

PSYCHIATRIC

| | | |
|--------------------------|-----|----|
| Memory loss or confusion | YES | NO |
| Nervousness | YES | NO |
| Depression | YES | NO |
| Insomnia | YES | NO |

GENITOURANARY

| | | |
|------------------------------|-----|----|
| Frequent urination | YES | NO |
| Burning or painful urination | YES | NO |
| Blood in urine | YES | NO |
| Kidney stones | YES | NO |

Anniston Orthopaedic Associates, P.A.
731 Leighton Avenue, Suite 300
Anniston, Alabama 36207
(256) 236 - 4121 MAIN
(256) 237 - 5254 FAX
www.AnnistonOrtho.com

Physician Signature