Mountain View Orthopaedics
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Review of Systems

Please indicate any present complaints.

Patient Name _____

Constitutional Symptoms ☐ NONE

Good general health lately	○ No	○ Yes
Recent weight change	○ No	○ Yes
Fever	○ No	○ Yes
Fatigue	○ No	○ Yes
Headaches	○ No	○ Yes

Eyes ☐ NONE

Eye disease or injury	○ No	○ Yes
Wear glasses/contact lenses	○ No	○ Yes
Blurred or double vision	○ No	○ Yes

Ear/Nose/Throat/Mouth ☐ NONE

Hearing loss or ringing	○ No	○ Yes
Earaches or drainage	○ No	○ Yes
Chronic sinus problem	○ No	○ Yes
Nose bleeds	○ No	○ Yes
Chronic rhinitis	○ No	○ Yes
Mouth sores	○ No	○ Yes
Bleeding gums	○ No	○ Yes
Bad breath or bad taste	○ No	○ Yes
Sore throat or voice change	○ No	○ Yes
Swollen glands in neck	○ No	○ Yes

Cardiovascular ☐ NONE

Heart trouble	○ No	○ Yes
Chest pain or angina	○ No	○ Yes
Palpitation	○ No	○ Yes
Shortness of breath w/ walking or lying flat	○ No	○ Yes
Swelling of feet or ankles	○ No	○ Yes

Gastrointestinal ☐ NONE

Loss of appetite	○ No	○ Yes
Change in bowel movements	○ No	○ Yes
Nausea or vomiting	○ No	○ Yes
Frequent diarrhea	○ No	○ Yes
Painful bowel movements or constipation	○ No	○ Yes
Rectal bleeding or blood in stool	○ No	○ Yes
Abdominal pain	○ No	○ Yes

Genitourinary ☐ NONE

Frequent urination	○ No	○ Yes
Burning or painful urination	○ No	○ Yes
Incontinence or dribbling	○ No	○ Yes
Kidney stones	○ No	○ Yes
Male testicle pain	○ No	○ Yes
Female pelvic pain	○ No	○ Yes

Musculoskeletal ☐ NONE

Joint pain	○ No	○ Yes
Joint stiffness or swelling	○ No	○ Yes
Weakness of muscle or joints	○ No	○ yes
Back pain	○ No	○ Yes
Cold extremities	○ No	○ Yes
Difficulty in walking	○ No	○ Yes
Muscle pain or cramps	○ No	○ Yes
Gout	○ No	○ Yes

Integumentary (skin, breast) ☐ NONE

Rash or itching	○ No	○ Yes
Change in skin color	○ No	○ Yes
Suspicious lesion	○ No	○ Yes

Neurological ☐ NONE

Frequent/recurring headaches	○ No	○ Yes
Light headed or dizzy	○ No	○ Yes
Convulsions or seizures	○ No	○ Yes
Numbness/tingling sensations	○ No	○ Yes
Tremors	○ No	○ Yes
Paralysis	○ No	○ Yes
Head injury	○ No	○ Yes
Migraines	○ No	○ Yes

Psychiatric ☐ NONE

Memory loss	○ No	○ Yes
Nervousness	○ No	○ Yes
Depression	○ No	○ Yes
Insomnia	○ No	○ Yes
Confusion	○ No	○ Yes

Endocrine ☐ NONE

Glandular or hormone problems	○ No	○ Yes
Excessive thirst	○ No	○ Yes
Excessive urination	○ No	○ Yes

Hematologic/Lymphatic ☐ NONE

Slow to heal after cut	○ No	○ Yes
Bleeding tendency	○ No	○ Yes
Bruising tendency	○ No	○ Yes
Anemia	○ No	○ Yes
Phlebitis	○ No	○ Yes
Past transfusion	○ No	○ Yes
Enlarged glands	○ No	○ Yes

Respiratory ☐ NONE

Chronic or frequent coughs	○ No	○ Yes
Spitting up blood	○ No	○ Yes
Shortness of breath	○ No	○ Yes
Wheezing	○ No	○ Yes

Allergies ☐ NONE

Drug reactions	○ No	○ Yes
Hives	○ No	○ Yes
Seasonal	○ No	○ Yes
Latex	○ No	○ Yes

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform my doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform necessary services I may need.

Patient's Signature: _____ Date (MM/DD/YYYY): ___ / ___ / ___

Physician's Signature: _____ Date (MM/DD/YYYY): ___ / ___ / ___