JEFFERSON ORTHOPEDIC CLINIC

Review of Systems

Any questions left blank will be considered not to be a problem or a "negative response".

Are you currently or have you had problems with your: If any are checked YES please explain.

Circle

Yes No Cardiovascular: (Blood Pressure, Chest Pain)___________________________________

Yes No Arthritis: (Rheumatoid, Osteoarthritis)___________________________________

Yes No Neurologic: (Numbness, Tingling, Balance)___________________________________

Yes No Constitutional: (Weight Loss, Diet, Development)___________________________________

Yes No Stomach Ulcers: ___________________________________

Yes No Diabetes: ___________________________________

Yes No Liver Disease: ___________________________________

Yes No Blood Clots: ___________________________________

Yes No Disabled: (How & When)___________________________________

PAST MEDICAL HISTORY: Please indicate any major surgeries or hospitalizations, and if there were complications.

Hospitalizations/ Surgeries (type)/ Major Injuries	Year	Complications (if any)

Have you ever had general anesthesia (put to sleep) Yes No If YES, Were there any problems:
Yes No If Yes, please explain the problem: ___________________________________

FAMILY HISTORY: Please complete to the best of your knowledge.

	Alive	Deceased	If deceased, cause of death	Health Status		
Mother			____________	Good	Poor	Excellent
Father			____________	Good	Poor	Excellent
Sister/Brother			____________	Good	Poor	Excellent
Children			____________	Good	Poor	Excellent

SOCIAL HISTORY: Please answer all questions.

Are you Employed? Yes No If Yes, Occupation: ___________________________________

Marital Status: Single Married Separated Widowed

Do you have children: Yes No Do you live with: Spouse Relatives Alone Other

Do you exercise: Yes No If yes, what type or kind of exercise? ______________________

Are you on any kind of special diet? Yes No If yes, What type or kind: ______________________

Have you had history of substance abuse? Yes No If yes, Explain: ______________________

Do you smoke? Yes No If yes, How long have you smoked?: __________ How many packs Per Day? __________

Do you drink alcohol? Yes No If yes, How much? __________ How Long: __________

Education: Check: Jr. High School GED High School College Graduate School Other: __________

Physicians Initials:____________________ Date:__________

PFSH + ROS Updated:

Updated:__________Int:_____/ Updated:__________Int:_____/ Updated__________Int:__________