The Christ Hospital
ORTHOPAEDIC ASSOCIATES
Freiberg Orthopaedics and Sports Medicine

Name: _____ Date: _____

REVIEW OF SYSTEMS	ARE YOU **CURRENTLY** EXPERIENCING ANY OF THE FOLLOWING CONDITIONS (*Circle Yes or No*)			If any yes answer, please explain below
General	Recent weight change	No	Yes	
Skin	Skin condition / cancer	No	Yes	
Head, eyes, ears, nose & throat (ENT)	Headaches	No	Yes	
	Dizziness / blacking out	No	Yes	
	Eye or hearing impairment	No	Yes	
	Sinus or throat trouble	No	Yes	
	Nosebleeds	No	Yes	
Neck	Thyroid disease	No	Yes	
	Enlarged glands	No	Yes	
Respiratory	Asthma	No	Yes	
	Difficulty breathing	No	Yes	
	Pleurisy or pneumonia	No	Yes	
Cardiovascular	Chest pain	No	Yes	
	Shortness of breath	No	Yes	
	Heart attack	No	Yes	
	High blood pressure	No	Yes	
	Blood clots in legs or lungs	No	Yes	
	Swelling of feet or legs	No	Yes	
	Poor circulation	No	yes	
	Irregular heartbeat	No	Yes	
Gastrointestinal (GI)	Ulcer	No	Yes	
	Gallbladder	No	Yes	
	Hepatitis / liver trouble	No	Yes	
	Bleeding with bowel movements	No	Yes	
	Hemorrhoids	No	Yes	
	Hiatal hernia / reflux	No	Yes	
Genitourinary (GU)	Loss of urine / incontinence	No	Yes	
	Frequent urination	No	Yes	
	Burning, painful urination	No	Yes	
	Blood in urine	No	Yes	
	Kidney stones / kidney disease	No	Yes	
Gynecological (GYN)	Bleeding or other problem	No	Yes	
	Breast masses	No	Yes	
Musculoskeletal	Fractures or other injuries	No	Yes	
	Back or neck pain	No	Yes	
Neurological	Seizures or other conditions	No	Yes	
	Neuropathy	No	Yes	
	Stroke	No	Yes	
	Chronic pain	No	Yes	
	Fibromyalgia	No	Yes	
Psychological	Depression or other problems	No	Yes	
Hematological	Blood disorder or cancer	No	Yes	
	Excessive bleeding after surgery / dental work	No	Yes	

Patient Signature: _____ Dr's Initials: _____ Date: _____

FOR OFFICE USE ONLY

HAVE THERE BEEN ANY CHANGES IN THE LIST ABOVE?

☐ Yes ☐ No Comments: _____
Patient Signature: _____ Date: _____ Dr's .Initials: _____ Date: _____

☐ Yes ☐ No Comments: _____
Patient Signature: _____ Date: _____ Dr's .Initials: _____ Date: _____

☐ Yes ☐ No Comments: _____
Patient Signature: _____ Date: _____ Dr's .Initials: _____ Date: _____

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