ROPER ST. FRANCIS
PHYSICIAN PARTNERS

Orthopaedic Review of Systems

Date: ________ **Name:** ____ **DOB:** _________________

Please check "admits" or "denies" to the following conditions:	**Admits**	**Denies**
Allergies/Immunology		
Allergies	______	______
Endocrine		
Gout	______	______
Thyroid Problems	______	______
Diabetes (Tablet or Insulin- **circle one**)	______	______
Respiratory		
Sleep Apnea	______	______
Asthma	______	______
COPD	______	______
Shortness of breath	______	______
Cardiovascular		
Circulatory Problems	______	______
Blood Clots/ HX of Blood Clots, DVT's, Stent? (**circle one**)	______	______
Heart Failure, High BP, Heart Disease, Heart Attack (**circle one**)	______	______
Bleeding Tendency	______	______
Gastrointestinal		
GERD	______	______
Musculoskeletal		
Pain at night	______	______
Arthritis	______	______
Rheumatoid Arthritis	______	______
Osteoporosis	______	______
Fibromyalgia	______	______
Chronic or Intermittent back pain	______	______
Weakness	______	______
Extremities		
Numbness/Tingling	______	______
Dominant Hand (Right, Left- **circle one**)		
Skin		
Skin Disorders (Rash, Dermatitis, Diabetic Ulcers, Psoriasis- **circle one**)	______	______
Neurologic		
Numbness/Tingling	______	______
Stroke or mini stroke	______	______
Loss of strength	______	______
Psychiatric		
Depression	______	______
Anxiety	______	______
Substance Abuse/Alcohol Abuse	______	______
General/Other		
Liver Disease/Hepatitis	______	______
Kidney Disease	______	______
Metal Allergies (jewelry irritate skin?)	______	______
Poor or slow healing	______	______
Cancer?	______	______
HIV/AIDS	______	______
Unexplained weight loss	______	______
Balance Problems	______	______
Active Dental Problems	______	______
Infection after surgery	______	______
Current or Recent Infection, Recent Fever? (**circle one**)	______	______