Precision Orthopaedics – Review of Systems

Patient Name: _____ Date: _____

Do You Currently Have Any of These Symptoms? (Please check all that apply):

_____ Fever _____ Fatigue _____ Night Sweats

Eyes, Ears, Nose, Throat Problems: _____ Headache _____ Vision Loss Other: _____

Lung Problems: _____ Cough _____ Shortness of Breath _____ Other: _____

Heart Problems: _____ Chest Pain _____ Poor Circulation _____ Irregular Heartbeat

Gastrointestinal Problems: _____ Constipation _____ Diarrhea _____ Nausea

_____ Vomiting _____ Other: _____

Genitouarinary Problems: _____ Painful Urination _____ Bloody Urine _____ Other _____

Endocrine Problems: _____ Cold Intolerance _____ Heat Intolerance _____ Other: _____

Neurologic Problems: _____ Difficulty Walking _____ Dizziness _____ Other: _____

Psychiatric Problems: _____ Anxiety _____ Depression _____ Bipolar Disorder

Musculoskeletal Problems: _____ Back Problems _____ Gout _____ Limited Range of Motion

_____ Broken Bones _____ Arthritis