RICHMOND BONE & JOINT CLINIC, P.A.

Review of Systems: Circle symptoms below you are currently having.

fever	back pain	anxiety
chills	joint pain	tension
sweats	joint swelling	depression
fatigue	muscle cramps	memory loss
weight loss	muscle weakness	difficulty sleeping
chest pains	stiffness	cold intolerance
fainting	arthritis	heat intolerance
ankle swelling	rash	weight change
leg swelling	itching	excessive urination
shortness of breath	skin dryness	abnormal bruising
cough	mole changes	bleeding
wheezing	weakness	hives
painful breathing	numbness	cancer _____
nausea/vomiting	persistent infections	stage _____
change in bowel habits		

List Your Medications and Conditions:

_____

_____

_____

_____

List Your Medications and Conditions:

_____

_____

_____

_____

Medical/Social History

Referring Physician: _____ Primary Care Physician: _____

Are you currently participating in an athletic sport? Yes No If yes, who is your athletic trainer? _____

Have you ever had any surgery? Yes No What kind? _____

Have you had orthopedic surgery? Yes No What kind?_____

Have you experienced surgery related problems? Yes No? Describe _____

If you have a fracture today, have you broken this bone before? Yes No

Do you have a history of: Hepatitis HIV Blood Transfusion

Family History

Circle All That Run In Your Family:

Heart Disease Rheumatoid Arthritis Bleeding Disorders
Connective Tissue Disorders Cancer Diabetes Muscular Dystrophy

Circle All That Apply:

Tobacco use? Cigarettes Cigars Smokeless/Chewing If so, how much? _____
Alcohol use? Current Previous Drinks/day?_____ What kind?_____ Last used?_____
Illegal Drug use? Injection Oral Smoking What kind?_____ Last used?_____

Patient Name: _____ **Patient Signature:** _____

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