



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:

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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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