



RICHMOND BONE & JOINT CLINIC, P.A.

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

- | | | |
|-----------------------|-------------------------|-----------------------|
| fiebre | dolor en la espalda | ansiedad |
| escalofrio | dolor en los huesos | tension |
| sudar | hinchazon de huesos | depresion |
| cansancio | calambre en los huesos | perdida de memoria |
| perdida de peso | debilidad de los huesos | dificultad de dorme |
| dolor en su pecho | rigido | intolerancia de frio |
| desmayo | artritis | intolerancia de calor |
| hinchazon de tobillo | rasche | cambio de peso |
| hinchazon de pierna | sensacion de picazon | xcesivo orina |
| falto de respiracion | sequedad de piel | anormal morado |
| tos | cambio de manchas | sangramiento |
| sibilante | debilidad | ronchas |
| problemas de respirar | entumecimiento | cancer _____ |
| nausea/vomito | temporal paralisis | stage _____ |
| cambio en intestino | | |

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? Si No If yes, who is your athletic trainer? _____

Has tenido cirugia? Si No What kind? _____

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

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

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

Has tenido historia de: Hepatitis HIV (sida) Sangre Transfusion

Historia de Familia

Circle All That Run In Your Family:

- Heart Disease Rheumatoid Arthritis Bleeding Disorders
- Desorden de connectico telido Cancer Diabetes Muscular Distrofia

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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