ORTHOPEDIC ASSOCIATES
OADoctors.com 800-824-9861

REVIEW OF SYMPTOMS

Patient Name:_____ DOB:_____

Constitutional		
Chills	☐ Yes	☐ No
Fever	☐ Yes	☐ No
Night/Day Sweats	☐ Yes	☐ No
Weight Loss	☐ Yes	☐ No
Weight Gain	☐ Yes	☐ No
Cardiology		
Chest Pain	☐ Yes	☐ No
Leg Swelling	☐ Yes	☐ No
Palpitations	☐ Yes	☐ No
Shortness of Breath	☐ Yes	☐ No
Respiratory		
Pain with Breathing	☐ Yes	☐ No
Cough	☐ Yes	☐ No
Coughing Blood	☐ Yes	☐ No
Wheezing	☐ Yes	☐ No
Musculoskeletal		
Swelling in Small Joints of Hands and Feet	☐ Yes	☐ No
Pain in Small Joints of Hands and Feet	☐ Yes	☐ No
Swelling in Large Joints	☐ Yes	☐ No
Pain in Large Joints	☐ Yes	☐ No
Fractures	☐ Yes	☐ No
Morning Stiffness	☐ Yes	☐ No
Great Toe Pain	☐ Yes	☐ No
Muscle Cramps	☐ Yes	☐ No
Calf Pain when Walking	☐ Yes	☐ No
Neurology		
Periods of Unconsciousness	☐ Yes	☐ No
Temporary Episodes of Leg Weakness	☐ Yes	☐ No
Gait Disturbances	☐ Yes	☐ No
Blurred Vision	☐ Yes	☐ No
Tingling/Numbness	☐ Yes	☐ No