BOULDER MEDICAL CENTER, P.C. ORTHO/PODIATRY REVIEW OF SYSTEMS - New Patients

Patient Name:_____ Date of Birth:_____
Please Print

Why are you seeing the Provider today?_____

_____

If this is an injury: Date of Injury_____ Have you already had an X-ray?_____ If Yes Where_____

Side? ___Left ___ Right How did it occur?_____

_____

Where did it occur? ☐ Work ☐ Home ☐ Recreational activities ☐ Other _____

Height_____ Weight_____ Dominant Hand? ___Right ___Left Shoe Size:_____

Tobacco Status and Usage	Quantity / Frequency
O Current every day smoker	
O Current some day smoker	
O Former smoker	NA
O Never smoked	NA

Alcohol Usage	Quantity / Frequency
O Yes	
O Never	NA
O Former	

Drug Usage
O Marijuana/ CBD
O Other

Caffeine Usage	Quantity / Frequency
O Yes	
O No	NA

Exercise	Frequency
O Yes	
O No	NA

Please mark with an "X" any symptoms you are currently experiencing

CONSTITUTIONAL
- ____ Chills
- ____ Fatigue
- ____ Fever
- ____ General discomfort
- ____ Night Sweats
- ____ Weight Gain
- ____ Weight Loss

HEENT
- ____ Blurred vision
- ____ Double vision
- ____ Trouble with speech
- ____ Ear drainage
- ____ Facial pain
- ____ Headache
- ____ Hearing loss
- ____ Hoarseness
- ____ Nasal congestion
- ____ Ringing in ears
- ____ Vertigo
- ____ Vision loss

RESPIRATORY
- ____ Chest pain (respiratory)
- ____ Cough
- ____ Shortness of breath
- ____ Recent infections
- ____ Known TB exposure
- ____ Wheezing

CARDIOVASCULAR
- ____ Chest pain
- ____ Bluish lips/nails
- ____ Heart murmur
- ____ Leg swelling
- ____ Fainting
- ____ Irregular heartbeat/palpitations

GASTROINTESTINAL
- ____ Abdominal pain
- ____ Constipation
- ____ Black tarry stools
- ____ Diarrhea
- ____ Heartburn
- ____ Jaundice
- ____ Loss of appetite
- ____ Nausea
- ____ Vomiting

GENITOURINARY
- ____ Painful urination
- ____ Frequent urination
- ____ Blood in urine
- ____ Urinary incontinence

METABOLIC / ENDOCRINE
- ____ Cold intolerance
- ____ Hair loss
- ____ Heat intolerance

NEUROLOGICAL
- ____ Difficulty walking
- ____ Dizziness
- ____ Poor coordination

NEUROLOGICAL (con't)
- ____ Memory loss
- ____ Muscle weakness
- ____ Tingling
- ____ Seizures
- ____ Tremors

PSYCHIATRIC
- ____ Anxiety
- ____ Depression
- ____ Insomnia

DERMATOLOGY
- ____ Contact allergy
- ____ Itchy skin
- ____ Rash
- ____ Skin infections
- ____ Skin lesions

MUSCULOSKELETAL

HEMATOLOGIC / LYMPHATIC
- ____ Bleeding
- ____ Bruising

IMMUNOLOGIC
- ____ Asthma
- ____ Bee sting allergies
- ____ Contact dermatitis
- ____ Environmental allergies
- ____ Food allergies
- ____ Seasonal allergies

(over)

MEDICAL AND SURGICAL HISTORY

CONDITION	TREATMENT	AGE AT ONSET / YEAR

FAMILY HISTORY

CONDITION	RELATIONSHIP	AGE AT ONSET

MEDICATION & SUPPLEMENTS

NAME OF MEDICATION	STRENGTH	HOW MANY PER DAY	REASON

FOOD/DRUG ALLERGIES

NAME OF FOOR OR DRUG	REACTION