



REVIEW OF SYSTEMS WORKSHEET

NAME: _____ DATE: _____

IN THE PAST MONTH, HAVE YOU EXPERIENCED ANY OF THE FOLLOWING?

(CIRCLE ALL THAT APPLY)

- | | | |
|----------------------|-----------------------|-------------------|
| NIGHT SWEATS | COUGH | UNUSUAL STRESS |
| FEVER | CHANGE IN BOWEL HABIT | ANXIETY |
| CHILLS | NAUSEA | NUMBNESS/TINGLING |
| WEIGHT LOSS | CONSTIPATION | MUSCLE WEAKNESS |
| WEIGHT GAIN | DIARRHEA | STIFFNESS |
| FAINTING | BRUISING | JOINT PAIN |
| CHEST PAIN | EXCESSIVE THIRST | JOINT SWELLING |
| IRREGULAR HEART BEAT | VOMITING | LEG SWELLING |
| WHEEZING | CHANGE IN URINATION | BLEEDING |
| SHORTNESS OF BREATH | PAINFUL URINATION | SWOLLEN GLANDS |
| | | NONE |

PLEASE GIVE DETAILS OF ALL THAT YOU HAVE CIRCLED ABOVE:



PATIENT HEALTH HISTORY SHEET

PLEASE PRINT LEGIBLY AND COMPLETE ALL INFORMATION

PATIENT NAME: _____

AGE: _____ HEIGHT: _____ WEIGHT: _____

WHAT ARE WE SEEING YOU FOR TODAY? LEFT / RIGHT (BODY PART): _____

IS THIS INJURY SPORTS RELATED? YES ___ NO ___ **DATE OF INJURY:** _____

WHERE DID INJURY OCCUR? (GEOGRAPHICAL LOCATION, NOT BODY PART): _____

() **WORKMAN COMP** HAVE YOU FILED A CLAIM? YES ___ NO ___

() **MOTOR VEHICLE** DO YOU HAVE A LAWYER? YES ___ NO ___

() **SCHOOL/ SPORTS** DID YOU BRING A CLAIM FORM? YES ___ NO ___

() **OTHER** PLEASE EXPLAIN _____

DID YOU BRING () X-RAYS () MRI () OTHER REPORT _____

CHIEF COMPLAINT (PLEASE DESCRIBE THE MAIN REASON FOR YOUR VISIT TODAY)

PLEASE GIVE THE DETAILS OF HOW THE INJURY OCCURRED:



MEDICAL INFORMATION:

PLEASE LIST ALL KNOWN DRUG ALLERGIES: _____

PLEASE LIST ALL CURRENT MEDICATIONS: _____

TOBACCO USE: () CIGARETTES () SNUFF/CHEWING TOBACCO () NON-SMOKER
 TOBACCO USE: _____ PACKS/DAY _____ YEARS _____ / ALCOHOL USE _____ DRINKS/DAY _____

PRIMARY CARE PHYSICIAN'S NAME: _____ PHONE: (_____) _____ - _____

RECENT ILLNESSES OR SYMPTOMS: _____

PREVIOUS SURGERY (PLEASE LIST AND GIVE DATES):

SURGERY	DATE
_____	_____
_____	_____
_____	_____
_____	_____

PLEASE LIST ANY MEDICAL CONDITIONS THAT ARE IN YOUR FAMILY: _____

FATHER () DECEASED () LIVING MOTHER () DECEASED () LIVING

**HAVE YOU EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING CONDITIONS OR ILLNESSES?
 (PLEASE CHECK ALL APPROPRIATE ANSWERS)**

- | | | | |
|--------------------------|----------------------|---------------------------|-------------------------|
| () LUPUS | () OBESITY | () HEART DISEASE | () COPD |
| () RHEUMATOID ARTHRITIS | () HEPATITIS | () HIGH CHOLESTEROL | () BLACK OUTS |
| () GOUT | () HIV/AIDS | () HIGH BLOOD PRESSURE | () ALZHEIMER'S DISEASE |
| () FIBROMYALGIA | () SLEEP APNEA | () PACEMAKER | () STROKE |
| () OSTEOARTHRITIS | () POOR CIRCULATION | () HEART ATTACK | () MULTIPLE SCLEROSIS |
| () ANEMIA | () CROHN'S DISEASE | () IRREGULAR HEART BEAT | () NEUROPATHY |
| () BLEEDING DISORDER | () HERNIA | () MITRAL VALVE PROLAPSE | () SEIZURES |
| () BROKEN BONES _____ | () LIVER DISEASE | () HEART STENT | () ANXIETY |
| () OSTEOPOROSIS | () KIDNEY PROBLEMS | () HEART FAILURE | () DEPRESSION |
| () CATARACTS | () KIDNEY STONES | () ASTHMA | () SCHIZOPHRENIA |
| () GLAUCOMA | () KIDNEY FAILURE | () EMPHYSEMA | () DEGENERATIVE DISC |
| () MACULAR DEGENERATION | () GALL STONES | () BRONCHITIS | () HERNIATED DISC |
| () CANCER (LIST BELOW) | () DIVERTICULITIS | () PNEUMONIA | () SCOLIOSIS |
| () DIABETES | () ULCERS | () TUBERCULOSIS | () NONE |



OTHER MEDICAL CONDITIONS/ILLNESSES NOT LISTED ABOVE: _____

PLEASE GIVE DETAILS IF YOU ANSWERED, "YES" TO ANY OF THE ABOVE: _____

I HEREBY GIVE PERMISSION TO **WALKER ORTHOPAEDICS** AND ITS STAFF TO PROVIDE MY DAUGHTER/SON WITH EVALUATION (INCLUDING X-RAYS) AND TREATMENT FOR HIS/HER INJURIES.

****DIVORCED PARENTS: IT IS THE POLICY OF THIS OFFICE THAT THE PARENT ACCOMPANYING THE CHILD FOR TREATMENT WILL BE HELD RESPONSIBLE FOR ALL CHARGES REGARDLESS OF THE INSURANCE OR FINANCIAL RESPONSIBILITY. WALKER ORTHOPAEDICS WILL NOT BILL OR DISCUSS TREATMENT WITH THE OTHER PARENT.**

I HEREBY AUTHORIZE WALKER ORTHOPAEDICS TO FURNISH INFORMATION TO INSURANCE CARRIER CONCERNING ME AND/OR MY DEPENDANTS ILLNESS AND TREATMENTS, AND I HEREBY ASSIGN TO THE PHYSICIAN (S) ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDANTS. I UNDERTAND AND AGREE THAT REGARDLESS OF MY INSURANCE STATUS, I AM ULTIMATELY RESPONSIBLE FOR THE BALANCE ON MY ACCOUNT AND / OR MY DEPENDANTS FOR ANY PROFESSIONAL SERVICES RENDERED. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE. I CERTIFY THAT THE INFORMATION ON THIS FORM IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND I WILL NOTIFY WALKER ORTHOPAEDICS OF ANY CHANGES. (A COPY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL.)

YOUR RECEIPT WILL PROVIDE ALL THE NECESSARY INFORMATION FOR YOU TO FILE WITH YOUR INSURANCE COMPANY IF OUR OFFICE IS NOT CONTRACTED WITH OR FILING TO YOUR INSURANCE CARRIER.

I WILL BE PAYING TODAY BY:

CASH _____ CHECK _____ DRIVERS LICENCE NUMBER _____

CREDIT CARD: MASTERCARD _____ VISA _____ ATM/DEBIT _____

SIGNATURE OF PATIENT: _____

DATE: _____

IF PATIENT IS A MINOR (UNDER THE AGE OF 18), PARENT OR LEGAL GUARDIAN MUST SIGN.