

**Greater Metropolitan Orthopedics and Rheumatology**  
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Name \_\_\_\_\_ Date \_\_\_\_\_

Age \_\_\_\_\_ Sex  M  F Referring Physician: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Chief Complaint today: \_\_\_\_\_

Briefly describe your symptoms: \_\_\_\_\_

When did you symptoms start? \_\_\_\_\_

Location? \_\_\_\_\_

Severity  Mild  Moderate  Severe \_\_\_\_\_

What makes it worse/better? \_\_\_\_\_

Any associated symptoms? \_\_\_\_\_

Any diagnosis given for this problem? \_\_\_\_\_

Any treatments given for this problem? \_\_\_\_\_

Medications and supplements: ( if you have an accurate separate list, skip section and give to front desk)

Medication Allergies: \_\_\_\_\_

Past Medical History  Cancer  Congestive Heart Failure  Diabetes  Emphysema

Gastroesophageal Reflux  GI Bleed  Gout  Heart Disease/Heart Attack  High Blood Pressure

High Cholesterol  Hypothyroidism  Kidney Disease  Osteoarthritis  Osteoporosis  Polymyositis

Psoriatic Arthritis  Psoriasis  Rheumatoid Arthritis  Sarcoidosis  Systemic Lupus

Sjogren's Syndrome  Scleroderma  Stroke  Systemic Lupus

Other conditions: \_\_\_\_\_

Past Surgical History: \_\_\_\_\_

Family Medical History  Ankylosing Spondylitis  Cancer  Diabetes  Gout  Heart Attacks  High Blood

Pressure  Osteoarthritis  Osteoporosis  Psoriasis/Psoriatic Arthritis  Rheumatoid Arthritis  Sarcoidosis

Scleroderma  Sjogren's Syndrome  Systemic Lupus  Stroke  Thyroid Disease or Goiter

	Age	Diseases	If deceased, cause of death
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Father	_____	_____	_____
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Mother	_____	_____	_____
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Siblings	_____	_____	_____
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_____	_____	_____	_____
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Marital Status  Single  Married  Divorced  Separated  Widowed  Partnered/significant other

Occupation \_\_\_\_\_  Retired  Homemaker  Unemployed

Alcohol  None  Minimal  Moderate  Heavy IV drug use

Smoking  Never  Previous  Current \_\_\_\_\_ how many years?  Currently pregnant (over please)

**Systems Review** (Please check any that apply)

**General**

- Fatigue
- Chills
- Night sweats
- Fatigue

**Cardiovascular**

- Chest pain
- Palpitations
- Swollen legs/feet
- Difficulty breathing at night
- Pain in legs

**Endocrine**

- Heat/cold intolerance
- Sudden weight gain/loss
- Frequent urination
- Increase hat/glove size

**Gastrointestinal**

- Poor appetite
- Abdominal pain
- Heartburn/indigestion
- Nausea
- Vomiting
- Diarrhea
- Bloody Stools
- Black or tarry stools
- Hepatitis
- Jaundice
- Gallstones

**Genital/Urinary**

- Pain with urination
- Flank or back pain
- Frequent/urgent urination
- Difficulty starting stream
- Kidney stones

**Hematology**

- Anemia
- Tendency to bruise/bleed easily
- Previous blood transfusions
- Blood clots in legs

**Skin**

- Rashes
- Sudden changes in growths/moles
- Itching or redness
- Excessive sweating
- Abnormal hair or nail growth

**Musculoskeletal**

- Wrist Pain     Left     Right
- Hand             Left     Right
- Fingers         Left     Right
- Elbow           Left     Right
- Shoulder       Left     Right
- Hips             Left     Right
- Knee            Left     Right
- Elbow           Left     Right
- Ankle           Left     Right
- Foot            Left     Right
- Lower back pain
- Neck pain
- Chest wall pain

**Neurological**

- Seizures
- Fainting
- Sudden weakness
- Tremors
- Memory loss
- Headaches
- Numbness or tingling

**Respiratory**

- Painful breathing
- Unusual shortness of breath
- Cough
- Previous exposure to tuberculosis

**OFFICE USE ONLY**

Ht. \_\_\_\_\_' \_\_\_\_\_" Wt. \_\_\_\_\_ lbs.

B/P \_\_\_\_\_ / \_\_\_\_\_ P \_\_\_\_\_

**X**

**Print Last Name**

Signature of patient (or parent if minor)