THE SHOULDER CENTER
AT BAYLOR UNIVERSITY MEDICAL CENTER AT DALLAS

Date:_____ **Name:** _____ **Date of Birth:**_____

Review of Systems

Do you have any complaints of:							**☐ None of the following/No to all**
Chest Pain	☐	Constipation	☐	Abnormal Bleeding	☐	Abnormal Menstrual Cycle	☐
Cough	☐	Cold Hands/Feet	☐	Growth Disturbance	☐	Incontinence of Bowel	☐
Depression	☐	Loss of Appetite	☐	Runny Nose	☐	Incontinence of Urine	☐
Ear Pain	☐	Muscle Weakness	☐	Numbness of Feet	☐	Sleep Disturbance	☐
Fainting	☐	Impotence	☐	Numbness of Hands	☐	Sputum Production	☐
Fever	☐	Balance Problems	☐	Shortness of Breath	☐	Visual Disturbance	☐
Mania	☐	Seizures	☐	Sore Throat	☐	Swelling in the Legs	☐
Skin Rash	☐	Skin Ulcers	☐	Wheezing	☐	Unexplained Weight Loss	☐
Vomiting	☐	Stomach Pain	☐	Weight Gain	☐	Other _____	

Family History

Does anyone in your family have any of the following?					**☐ None of the following/No to all**
Osteoporosis/Osteopenia?	☐	Blood Clots?	☐	Cholesterol problems?	☐
Diabetes?	☐	Arthritis?	☐	Premature menopause?	☐
High Blood Pressure?	☐	Cancer?	☐	Other_____	
Heart Disease?	☐	Thyroid disease?	☐		

Social History

Do you smoke? Yes No Packs/day?_____ Smokeless varieties_____
How many years have you or did you smoke? _____ When did you quit? _____
Do you drink alcohol? Yes No How often? ☐Daily ☐____days/week
Marital History: M S D W
Current or most recent Employer_____
Are you currently working? Yes No If not, how long have you been off work?_____

Current Medications (include name and dosage) ☐ None

BAYLOR University Medical Center at Dallas