**REVIEW OF SYSTEMS**

 What symptoms you are having today or regularly.

|  |  |  |
| --- | --- | --- |
|  |  |  |
| * Fever >100
 | * Shortness of Breath
 | * Weakness
 |
|  |  |  |
| * Weight Change
 | * Abdominal Pain
 | * Numbness
 |
|  |  |  |
| * Ear Pain
 | * Vomiting
 | * Dizziness
 |
|  |  |  |
| * Nose Bleeds
 | * Diarrhea
 | * Headaches
 |
|  |   |   |
| * Sinus Problems
 | * Blood in Stool
 | * Fatigue
 |
|  |   |  |
| * Mouth Ulcer
 | * Bowel Incontinence
 | * Swollen Glands
 |
|  |   |   |
| * Tooth Infection
 | * Urinary Loss of Control
 | * Easy Bruising
 |
| * Chest Pain
 | * Blood in Urine
 | * Exposure to HIV
 |
| * Cough
 | * Pain in Joints
 | * None
 |
|  |  |  |
| * Wheezing
 | * Rash
 |  |

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I may restrict the individuals or organizations to which my health care information is released and I may revoke my authorization to you at any time. This revocation must be given to Orthonow in writing and sent to their address.

In the event we cannot contact you, please list family members or other persons, if any, whom we may inform about your general medical condition and diagnosis:

**NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PHONE NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

May we leave messages regarding your treatment, billing, insurance, or other aspects associated

with your care on your home answering machine or voicemail?

**SIGNATURE OF PATIENT /GUARDIAN: \_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**(MUST BE 18 YEARS OLD OR OLDER TO SIGN)**