



BRET SOKOLOFF, MD

REVIEW OF SYSTEMS

What symptoms you are having today or regularly.

- | | | |
|---|--|--|
| <input type="checkbox"/> Fever >100 | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Weakness |
| <input type="checkbox"/> Weight Change | <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Ear Pain | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Frequent Nose Bleeds | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Blood in Stool | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Mouth Ulcer | <input type="checkbox"/> Bowel Incontinence | <input type="checkbox"/> Swollen Glands |
| <input type="checkbox"/> Tooth Infection | <input type="checkbox"/> Urinary Loss of Control | <input type="checkbox"/> Easy Bruising |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Blood in Urine | <input type="checkbox"/> Exposure to HIV |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Pain in Joints | <input type="checkbox"/> None |
| <input type="checkbox"/> Wheezing | <input type="checkbox"/> 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 can not 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? Yes No

SIGNATURE OF PATIENT /GUARDIAN: _____ DATE: _____
(MUST BE 18 YEARS OLD OR OLDER TO SIGN)