RAMA E. CHANDRAN, M.D.
SHAUN E. CHANDRAN, M.D.
ORTHOPAEDIC SURGERY
(310) 644-1151 FAX (310) 644-3115

4477 W. 118TH STREET, SUITE 402
HAWTHORNE, CALIFORNIA 90250

4201 TORRANCE BLVD SUITE 310
TORRANCE, CA 90503

Review Of Systems

General/Constitutional

Fatigue	O Yes	O No
Weight gain	O Yes	O No
Weight loss	O Yes	O No
Fever	O Yes	O No
Night sweats	O Yes	O No
Shortness of Breath	O Yes	O No

Respiratory

Chest pain	O Yes	O No
Cough	O Yes	O No

Skin

Rash	O Yes	O No
Discoloration	O Yes	O No
Photosensitivity	O Yes	O No

Gastrointestinal

Constipation	O Yes	O No
Diarrhea	O Yes	O No
Nausea	O Yes	O No
Heartburn	O Yes	O No

Genitourinary

Painful urination	O Yes	O No
Frequent urination	O Yes	O No

Neurologic

Gait abnormality	O Yes	O No
Coordination	O Yes	O No
Tingling/Numbness	O Yes	O No

Psychiatric

Substance abuse	O Yes	O No
Difficulty sleeping	O Yes	O No
Anxiety	O Yes	O No

Allergy/Immunology

Sneezing	O Yes	O No
Wheezing	O Yes	O No

Cardiovascular

Chest pain at rest	O Yes	O No
Weakness	O Yes	O No
Palpitations	O Yes	O No

Ophthalmologic

Blurred vision	O Yes	O No
Diminished visual acuity	O Yes	O No

ENT

Decreased hearing	O Yes	O No
Ringing in the ears	O Yes	O No
Sinus pain	O Yes	O No

Hematology

Easy bruising	O Yes	O No
Prolonged bleeding	O Yes	O No
Recent transfusion	O Yes	O No

Musculoskeletal

Painful joints	O Yes	O No
Swollen joints	O Yes	O No
Joint stiffness	O Yes	O No
Trauma to arm(s)	O Yes	O No
Trauma to hip(s)	O Yes	O No
Trauma to knee(s)	O Yes	O No
Trauma to ankle(s)	O Yes	O No
Sciatica	O Yes	O No
Weakness	O Yes	O No

Patient Name: _____

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Past Medical History

Hypercholesterolemia	O Yes	O No	Hepatitis C	O Yes	O No
Hypothyroidism	O Yes	O No	Hepatitis B	O Yes	O No
Atrial fibrillation	O Yes	O No	Heart murmur	O Yes	O No
Arthritis	O Yes	O No	Bowel disorders	O Yes	O No
Asthma	O Yes	O No	Osteoporosis	O Yes	O No
Depression	O Yes	O No	Diabetes, type I	O Yes	O No
Obesity	O Yes	O No	Diabetes, type I I	O Yes	O No
Urinary incontinence	O Yes	O No	Emphysema	O Yes	O No
Sleep apnea	O Yes	O No	Stroke	O Yes	O No
Pulmonary embolism	O Yes	O No	Arthritis, rheumatoid	O Yes	O No
Cardiomyopathy	O Yes	O No	Hyperlipidemia	O Yes	O No
Hypertension	O Yes	O No	Renal failure	O Yes	O No
			Deep vein thrombosis	O Yes	O No

Patient Name: _____