

Musculoskeletal Review of Systems

MUSCULOSKELETAL REVIEW OF SYSTEMS

Patient's Name: _____ Date of Birth: _____ dd / mm / yyyy

Gender: _____

Relevant Medical History:

Referring Physician's Name: _____

Joint Swelling

☐ Present ☐ Absent

Joint Pain or Arthralgias

☐ Present ☐ Absent

Muscle Pain/Weakness or Myalgias

☐ Present ☐ Absent

Back Pain

☐ Present ☐ Absent

Movement or Physical Activity

☐ Present ☐ Absent

Changes in Range of Motion of Joints

☐ Present ☐ Absent

Bone Fractures or Pain

☐ Present ☐ Absent

Summary or Additional Notes: