REVIEW OF SYSTEMS

Surgical Associates, P.C. (Rev. Nov, 2016)

Name (Please Print)	Date of Birth Age	Today's Date

Referring Physician	Primary Care Physician (if different from Referring Physician)

Reason for today's visit?

Please check all that apply:

	Yes	No
General:		
Weakness or Fatigue	☐	☐
Recent weight change	☐	☐
Fever	☐	☐
Head, Ears, Eyes, Nose, Mouth, Throat:		
Frequent. nose bleeds	☐	☐
Swollen glands	☐	☐
Difficulty swallowing	☐	☐
Cardiovascular:		
High blood pressure	☐	☐
Abnormal heart beat - skipped or extra beats	☐	☐
Enlarged heart, abnormal heart or heart failure	☐	☐
Treated for chest pain or heart attack	☐	☐
Respiratory:		
Severe shortness of breath	☐	☐
Coughing up blood	☐	☐
Asthma	☐	☐
Gastrointestinal:		
Recurrent indigestion or heartburn	☐	☐
Major changes in bowel movements - size, frequency,. stool appearance, etc.	☐	☐
Rectal bleeding	☐	☐
Nausea or vomiting	☐	☐
Chronic intestinal problems	☐	☐
Genitourinary:		
Bladder or kidney infections	☐	☐
Blood in urine	☐	☐
Kidney Stones	☐	☐
Difficulty urinating	☐	☐

	Yes	No
Musculoskeletal:		
Walking or balancing difficulties	☐	☐
Frequent muscles cramps	☐	☐
Breast:		
Nipple discharge or discoloration	☐	☐
Breast mass or lumps	☐	☐
Extreme breast tenderness	☐	☐
History of breast infection or injury	☐	☐
Skin:		
Skin cancer: type?/ location? _____	☐	☐
Change in a mole or birth mark: location? _____	☐	☐
Neurological:		
Seizures	☐	☐
Fainting or blackouts	☐	☐
Endocrine:		
Thyroid trouble	☐	☐
Diabetes	☐	☐
Hematologic/Lymphatic:		
Anemia / low blood count	☐	☐
Tendency for bleeding or severe bruising	☐	☐
Blood Clots	☐	☐
History of chronic infections/ swollen lymph nodes/ glands	☐	☐
Allergic/Immunologic:		
HIV positive	☐	☐
Tuberculosis/ positive skin test	☐	☐
Hepatitis	☐	☐

FEMALES ONLY: Are you pregnant? ☐ No ☐ Yes If you have children, how many?

Date of your last period?

MD Signature _____ **Date** _____