

**REVIEW OF SYSTEMS**  
Surgical Associates, P.C. (Rev. June 24, 2004)

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:***

**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

**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:**

- History of skin cancer: type?/ location?  
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- Change in a mole or birth mark: location?  
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**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

<b>FEMALES ONLY:</b> Are you pregnant? <input type="checkbox"/> No <input type="checkbox"/> Yes.	If you have children, how many?
Date of your last period?	