SURGICAL CONTSULTING PLLC - REVIEW OF SYSTEMS

Patient Name: _____ **Today's Date:** _____

Do you now or have you had any problems related to the following systems? Circle YES or NO for each

Constitutional Symptoms
Fever Y☐ N☐
Chills Y☐ N☐
Abnormal weight loss/gain Y☐ N☐
Other _____

Eyes
Blurred vision Y☐ N☐
Double vision Y☐ N☐
Eye pain Y☐ N☐
Other _____

Allergic/Immunologic
Hay fever Y☐ N☐
Drug allergies Y☐ N☐
Food allergies Y☐ N☐
Other _____

Neurological
Seizures Y☐ N☐
Tremors Y☐ N☐
Nerve pain Y☐ N☐
Dizzy spells Y☐ N☐
Numbness/Tingling Y☐ N☐
Other _____

Genitourinary
Painful urination Y☐ N☐
Urinary frequency Y☐ N☐
Scant urination Y☐ N☐
Frequent UTI's Y☐ N☐
Urinary incontinence Y☐ N☐
Prostate problems Y☐ N☐
Other _____

Hematologic / Lymphatic
Swollen / Enlarged nodes Y☐ N☐
Excessive bleeding Y☐ N☐
Other _____

Digestive System
Heartburn Y☐ N☐
Diarrhea Y☐ N☐
Constipation Y☐ N☐
Food intolerance Y☐ N☐
Nausea Y☐ N☐
Belching Y☐ N☐
Bloating Y☐ N☐
Digestive pain Y☐ N☐
Other _____

Integumentary
Skin rash Y☐ N☐
Easy bruising Y☐ N☐
Nail problems Y☐ N☐
Other _____

Musculoskeletal
Joint pain Y☐ N☐
Joint swelling Y☐ N☐
Back pain Y☐ N☐
Difficulty ambulating Y☐ N☐
Other _____

Head / Ear / Nose / Throat / Mouth
Ear or sinus pain Y☐ N☐
Nasal obstruction Y☐ N☐
Sore throat Y☐ N☐
Hearing loss Y☐ N☐
Headache Y☐ N☐
Other _____

Cardiovascular
Chest pain Y☐ N☐
Palpitations/Irregular beats Y☐ N☐
Calf pain or heavy legs Y☐ N☐

Respiratory / Lungs
Wheezing/Shortness of breath Y☐ N☐
Frequent coughs Y☐ N☐
Sputum Y☐ N☐
Asthma Y☐ N☐
Other _____

Breasts
Implants Y☐ N☐
Discharge Y☐ N☐
Fibrocystic disease Y☐ N☐
Lumps Y☐ N☐
Breast pain Y☐ N☐
Date of last mammo _____
Other _____

Mentrual
Last period: _____

Last Pap: _____

Menopause Date: _____

Other _____