REVIEW OF SYSTEMS

PATIENT NAME____

Please check (√) “yes or “no” to each problem on the list below:

CONSTITUTIONAL

❑ No ❑ Yes Good general health lately
❑ No ❑ Yes Recent weight change
❑ No ❑ Yes Decreased appetite
❑ No ❑ Yes Fevers/night sweats
❑ No ❑ Yes Fatigue/weakness
❑ No ❑ Yes Headaches

EYES

❑ No ❑ Yes Change in vision
❑ No ❑ Yes Eye disease or injury

EARS/NOSE/THROAT/MOUTH

❑ No ❑ Yes Difficult hearing/ringing in ears
❑ No ❑ Yes Problems with teeth/gums

CARDIOVASCULAR

❑ No ❑ Yes Heart trouble
❑ No ❑ Yes Chest pain or angina pectoris
❑ No ❑ Yes Palpitation
❑ No ❑ Yes Shortness of breath with walking or lying flat
❑ No ❑ Yes Swelling of feet, ankles, or hands
❑ No ❑ Yes High blood pressure

CHEST/BREAST

❑ No ❑ Yes Breast lump
❑ No ❑ Yes Breast pain
❑ No ❑ Yes Nipple discharge

RESPIRATORY

❑ No ❑ Yes Cough/wheeze
❑ No ❑ Yes Difficulty breathing

GASTROINTESTINAL

❑ No ❑ Yes Loss of appetite
❑ No ❑ Yes Change in bowel movements
❑ No ❑ Yes Nausea or vomiting
❑ No ❑ Yes Frequent diarrhea
❑ No ❑ Yes Painful bowel movements or constipation
❑ No ❑ Yes Rectal bleeding or blood in stool
❑ No ❑ Yes Abdominal pain
❑ No ❑ Yes Ulcer (stomach)

GENITOURINARY

❑ No ❑ Yes Kidney disease

MUSCULOSKELETAL

❑ No ❑ Yes Muscle/joint pain

SKIN

❑ No ❑ Yes Rash/mole change
❑ No ❑ Yes Rash or itching
❑ No ❑ Yes Change in skin color
❑ No ❑ Yes Change in hair or nails
❑ No ❑ Yes Varicose veins

NEUROLOGICAL

❑ No ❑ Yes Headaches
❑ No ❑ Yes Dizziness/light-headedness
❑ No ❑ Yes Numbness
❑ No ❑ Yes Memory loss
❑ No ❑ Yes Loss of coordination

BLOOD/LYMPHATIC

❑ No ❑ Yes Slow to heal after cuts
❑ No ❑ Yes Bleeding or bruising tendency
❑ No ❑ Yes Anemia
❑ No ❑ Yes Blood clots
❑ No ❑ Yes Blood transfusion
❑ No ❑ Yes Enlarged glands

ALLERGIC/IMMUNOLOGIC

❑ No ❑ Yes HIV

History of skin reaction or other adverse reaction to:

❑ No ❑ Yes Penicillin or other antibiotics
❑ No ❑ Yes Morphine, Demerol, or other narcotics
❑ No ❑ Yes Other drugs/medications

ENDOCRINE

❑ No ❑ Yes Glandular or hormone problem
❑ No ❑ Yes Thyroid disease
❑ No ❑ Yes Diabetes (insulin or non insulin - circle one)
❑ No ❑ Yes Excessive thirst or urination

PSYCHIATRIC

❑ No ❑ Yes Memory loss or confusion
❑ No ❑ Yes Problems with sleep

OTHER

❑ No ❑ Yes Previous anesthesia problems
❑ No ❑ Yes Other____________________

FOR PHYSICIAN USE ONLY - DO NOT WRITE IN THIS BOX

Physician reviewed by:____ Date__________________________

Updated / Reviewed: Date__________________________ Date__________________________