Review of Systems

Name: ___________________________  Date: ________________

Please Indicate if you are feeling or have had any of the following symptoms in the past?

† Recent Weight Change
† Fatigue, Fever
† Rashes/Unusual Lumps or Sores
† Itching or Dryness
† Headache
† Head Injury
† Eye Pain
† Double vision
† Blurred vision, spots, specks, flashing lights
† History of glaucoma
† Ringing in the ears
† Dizziness
† Earaches, Infection, Discharge
† Use of Hearing Aids
† Recent Colds or Bronchitis
† Nasal stuffiness, Discharge, Nosebleeds
† Toothache, Dental Abscess or Sores
† Sore throat, Hoarseness
  Date of last Dental Exam: __________________________

† Heart trouble, Chest pain, Palpitations
† Rheumatic fever, Heart Murmur, Mitral Valve Prolapse
† History of Angina
† High Blood Pressure
† History of Heart Attack (MI)
  Date of Last Stress Test: __________________________

† Nausea or Vomiting
† Diarrhea or Abdominal Pain
† Blood in the stool or History of Colon Cancer
† History of Hepatitis
† History of HIV
† Pain or burning while urinating
† Blood in the urine
† History of infection/UTI or Kidney
  Date of last infection: __________________________

† History of BPH
† Intermittent Claudication or Leg Cramps
† Blood Clots in the legs/DVT
† History of Pulmonary Embolism
† Numbness or Tingling
† Extremity Weakness or Parathesia
† Seizures
† History of TIA or Stroke

If you indicated any of the above, please provide more specific information below. (Date of last evaluation, Acute vs. Chronic problem, Stable vs. Unstable)

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Arthroscopic Surgery  ❖  Joint Replacements  ❖  Fractures  ❖  Sports Medicine
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