LEON P. MEAD, M.D., P.A.

Diplomats of the American Board of Orthopaedic Surgery

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:
_____

Swollen Glands, Goiter (Thyroid)
Cough, History of Chronic Cough, Sputum production
Wheezing, Asthma, COPD/Bronchitis, Emphysema
History of Pneumonia or tuberculosis pleurisy
Date of last Chest 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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