CAPITAL SURGEONS GROUP, PLLC

REVIEW OF SYSTEMS

NAME OF PATIENT: ____________________ DATE OF BIRTH: __________ DATE: __________

PLEASE CHECK YES OR NO FOR ALL ITEMS

CONSTITUTIONAL:	YES	NO
WEIGHT LOSS	☐	☐
WEIGHT GAIN	☐	☐
FEVER	☐	☐
CHILLS	☐	☐
WEAKNESS	☐	☐
FATIGUE	☐	☐
NIGHT SWEATS	☐	☐
OTHER: ____________		

EYES:	YES	NO
VISUAL LOSS	☐	☐
BLURRED VISION	☐	☐
DOUBLE VISION	☐	☐
YELLOW EYES	☐	☐
OTHER: ____________		

EARS, NOSE, THROAT, MOUTH:	YES	NO
RINGING IN EARS	☐	☐
HEARING LOSS	☐	☐
SNEEZING	☐	☐
CONGESTION	☐	☐
RUNNY NOSE	☐	☐
SORE THROAT	☐	☐
HOARSENESS	☐	☐
OTHER: ____________		

CARDIOVASCULAR:	YES	NO
CHEST PAIN	☐	☐
PALPITATIONS	☐	☐
LEG SWELLING	☐	☐
OTHER: ____________	☐	☐

RESPIRATORY:	YES	NO
SHORTNESS OF BREATH	☐	☐
PRODUCTIVE COUGH	☐	☐
WHEEZING	☐	☐
OTHER: ____________		

ENDOCRINE:	YES	NO
HEAT INTOLERANCE	☐	☐
COLD INTOLERANCE	☐	☐
SWEATING	☐	☐
EXCESSIVE URINATION	☐	☐
EXCESSIVE THIRST	☐	☐
OTHER: ____________		

NEUROLOGICAL:	YES	NO
LEG OR ARM WEAKNESS	☐	☐
LEG OR ARM NUMBNESS	☐	☐
HEADACHE	☐	☐
DIZZINESS	☐	☐
SEIZURES	☐	☐
BLACKOUTS	☐	☐
OTHER: ____________		

GASTROINTESTINAL:	YES	NO
NAUSEA	☐	☐
REFLUX / HEARTBURN	☐	☐
ANOREXIA	☐	☐
VOMITING	☐	☐
DIARRHEA	☐	☐
CONSTIPATION	☐	☐
BLOOD IN STOOL	☐	☐
BLACK TARRY STOOLS	☐	☐
ABDOMINAL PAIN	☐	☐
OTHER: ____________	☐	☐

GENITOURINARY:	YES	NO
PAINFUL URINATION	☐	☐
INCREASED FREQUENCY	☐	☐
INCREASED URGENCY	☐	☐
BLOOD IN URINE	☐	☐
OTHER: ____________		

MUSCULOSKELETAL:	YES	NO
MUSCLE OR BACK PAIN	☐	☐
JOINT PAIN	☐	☐
STIFFNESS	☐	☐
OTHER: ____________		

SKIN:	YES	NO
LESIONS	☐	☐
RASHES	☐	☐
ITCHING	☐	☐
OTHER: ____________		

HEMATOLOGIC/LYMPHATIC:	YES	NO
EASY BRUISING OR BLEEDING	☐	☐
ENLARGED NODES	☐	☐
OTHER: ____________		

PSYCHIATRIC:	YES	NO
DEPRESSION	☐	☐
ANXIETY	☐	☐
BIPOLAR	☐	☐
OTHER: ____________		

ALLERGIC/IMMUNOLOGY:	YES	NO
ASTHMA	☐	☐
SKIN SENSITIVITY	☐	☐
OTHER: ____________		

____

SIGNATURE **DATE**