SOUTHWEST BARIATRIC SURGEONS, PLLC

REVIEW OF SYSTEMS

NAME OF PATIENT: _____ DATE OF BIRTH: _____ DATE: _____

PLEASE CHECK YES OR NO FOR ALL ITEMS

	YES	NO
CONSTITUTIONAL:		
WEIGHT LOSS	☐	☐
WEIGHT GAIN	☐	☐
FEVERS	☐	☐
CHILLS	☐	☐
WEAKNESS	☐	☐
FATIGUE	☐	☐
NIGHT SWEATS	☐	☐
OTHER: _____		
EYES:		
VISUAL LOSS	☐	☐
BLURRED VISION	☐	☐
DOUBLE VISION	☐	☐
YELLOW EYES	☐	☐
OTHER: _____		
EARS, NOSE, THROAT, MOUTH:		
RINGING IN EARS	☐	☐
HEARING LOSS	☐	☐
SNEEZING	☐	☐
CONGESTION	☐	☐
RUNNY NOSE	☐	☐
SORE THROAT	☐	☐
HOARSENESS	☐	☐
OTHER: _____		
CARDIOVASCULAR:		
CHEST PAIN	☐	☐
PALPITATIONS	☐	☐
LEG SWELLING	☐	☐
OTHER: _____	☐	☐
RESPIRATORY:		
SHORTNESS OF BREATH	☐	☐
PRODUCTIVE COUGH	☐	☐
WHEEZING	☐	☐
OTHER: _____		
ENDOCRINE:		
HEAT INTOLERANCE	☐	☐
COLD INTOLERANCE	☐	☐
SWEATING	☐	☐
EXCESSIVE URINATION	☐	☐
EXCESSIVE THIRST	☐	☐
OTHER: _____		
NEUROLOGICAL:		
LEG OR ARM WEAKNESS	☐	☐
LEG OR ARM NUMBNESS	☐	☐
HEADACHE	☐	☐
DIZZINESS	☐	☐
SEIZURES	☐	☐
BLACKOUTS	☐	☐
OTHER: _____		

	YES	NO
GASTROINTESTINAL:		
NAUSEA	☐	☐
REFLUX / HEARTBURN	☐	☐
ANOREXIA	☐	☐
VOMITING	☐	☐
DIARRHEA	☐	☐
CONSTIPATION	☐	☐
BLOOD IN STOOL	☐	☐
BLACK TARRY STOOLS	☐	☐
ABDOMINAL PAIN	☐	☐
OTHER: _____	☐	☐
GENITOURINARY:		
PAINFUL URINATION	☐	☐
INCREASED FREQUENCY	☐	☐
INCREASED URGENCY	☐	☐
BLOOD IN URINE	☐	☐
OTHER: _____		
MUSCULOSKELETAL:		
MUSCLE OR BACK PAIN	☐	☐
JOINT PAIN	☐	☐
STIFFNESS	☐	☐
OTHER: _____		
SKIN:		
LESIONS	☐	☐
RASHES	☐	☐
ITCHING	☐	☐
OTHER: _____		
HEMATOLOGIC/LYMPHATIC:		
EASY BRUISING OR BLEEDING	☐	☐
ENLARGED NODES	☐	☐
OTHER: _____		
PSYCHIATRIC:		
DEPRESSION	☐	☐
ANXIETY	☐	☐
BIPOLAR	☐	☐
OTHER: _____		
ALLERGIC/IMMUNOLOGY:		
ASTHMA	☐	☐
SKIN SENSITIVITY	☐	☐
OTHER: _____		

SIGNATURE **DATE**