

Agave Surgical Associates

Review of Systems

Name: _____

Date of Birth: _____

Please check the box next to any of the following symptoms or problems you may have experienced recently to discuss them with you doctor.

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| <p><u>Constitutional</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Fatigue <input type="checkbox"/> Fever, chills or sweats <input type="checkbox"/> Decreased appetite <input type="checkbox"/> Increased appetite <input type="checkbox"/> Sudden weight loss <input type="checkbox"/> Sudden weight gain <p><u>HEENT</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Burning in eyes <input type="checkbox"/> Blurred vision <input type="checkbox"/> Visual loss <input type="checkbox"/> Ringing of the ears <input type="checkbox"/> Vertigo <input type="checkbox"/> Hearing loss <input type="checkbox"/> Earache <input type="checkbox"/> Nose bleeds <input type="checkbox"/> Prolonged hoarseness <input type="checkbox"/> Sinus trouble/congestion <p><u>Respiratory</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Chronic cough <input type="checkbox"/> Wheezing <input type="checkbox"/> Bluish discoloration of skin <input type="checkbox"/> Difficulty breathing <input type="checkbox"/> Painful respiration <input type="checkbox"/> Coughing up blood <input type="checkbox"/> Excessive phlegm <input type="checkbox"/> Shortness of breath <p><u>Cardiovascular</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Chest pain <input type="checkbox"/> Swollen ankles <input type="checkbox"/> Irregular heartbeat/palpitations) <p><u>Vascular</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Coldness to extremities <input type="checkbox"/> Swelling to extremities <input type="checkbox"/> Pain when walking <input type="checkbox"/> Ulcer(s) <input type="checkbox"/> Varicose veins | <p><u>Gastrointestinal</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Bloating/swelling <input type="checkbox"/> Change in appetite <input type="checkbox"/> Nausea <input type="checkbox"/> Bloody/black stool <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Heartburn <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Rectal bleeding <input type="checkbox"/> Vomiting <p><u>Genitourinary</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Loss of control of urine <input type="checkbox"/> Painful urination <input type="checkbox"/> Frequent urination <input type="checkbox"/> Urinating more than 2x a night <input type="checkbox"/> Blood in urine <p><u>FEMALE</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Family history of breast cancer <input type="checkbox"/> Breast mass/tenderness <input type="checkbox"/> Nipple discharge <input type="checkbox"/> Vaginal delivery(s) <input type="checkbox"/> C-section(s) <p><u>MALE</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Impotence <input type="checkbox"/> Enlarged prostate <input type="checkbox"/> Lump in groin <input type="checkbox"/> Testicular mass <p><u>Metabolic/Endocrine</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Heat intolerance <input type="checkbox"/> Cold intolerance <input type="checkbox"/> Excessive appetite <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Chronically overweight <input type="checkbox"/> Chronically underweight <p><u>Psychological</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Feeling depressed <input type="checkbox"/> Thoughts of suicide <input type="checkbox"/> Difficulty sleeping <input type="checkbox"/> Under Psychiatric care | <p><u>Neurological</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Headaches <input type="checkbox"/> Memory loss <input type="checkbox"/> Tremors/weakness <input type="checkbox"/> Neuropathy <input type="checkbox"/> Numbness/tingling <input type="checkbox"/> Dizziness/light-headedness <input type="checkbox"/> Seizures <input type="checkbox"/> Fainting spells <p><u>Skin</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Skin rashes <input type="checkbox"/> Dry skin/itching <input type="checkbox"/> Suspicious skin lesions <p><u>Musculoskeletal</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Back pain <input type="checkbox"/> Bone/joint pain <input type="checkbox"/> Muscle weakness <input type="checkbox"/> Muscle cramps <p><u>Hematologic</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Easy Bleeding <input type="checkbox"/> Easy Bruising <p><u>Immunological</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Hay fever (allergies) <input type="checkbox"/> Food allergies <input type="checkbox"/> "Bee" sting allergies <p><u>FAMILY MEDICAL HISTORY:</u></p> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> |
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