

COLON RECTAL SURGICAL ASSOCIATES

Patient Name: _____ Today's Date: _____

REVIEW OF SYSTEMS

Please circle Yes or No:

GENERAL:

Y N Fatigue
Y N Weight loss
Y N Decrease in appetite

CARDIOVASCULAR

Y N Chest pain
Y N Irregular heart beats
Y N Murmur, Palpitations
Y N Shortness of breath
Y N Heart attack
Y N Ankle Swelling

RESPIRATORY

Y N Wheezing
Y N Cough
Y N Coughing blood
Y N Pain with breathing

GENITOURINARY

Y N Urinary incontinence
Y N Urinary frequency
Y N Hesitancy
Y N Blood in urine
Y N Nocturia (nighttime urination)
Y N Pain with urination
Y N Impotence
Y N Menopause, Irreg. menses

ENDOCRINE

Y N Excess thirst
Y N Thyroid problems
Y N Diabetes

MUSCULOSKETAL

Y N Joint pain
Y N Back pain
Y N Muscle aches
Y N Joint swelling
Y N Decrease in mobility

HEME/LYMPH

Y N Bleeding tendency
Y N Enlarged lymph nodes
Y N Anemia
Y N HIV+
Y N Hepatitis
Y N High cholesterol

SKIN

Y N Yellow/jaundice
Y N Rash
Y N Itching
Y N Easy bruising
Y N Skin Cancer

EYES:

Y N Vision Change
Y N Cataracts
Y N Inflammation

HEAD, EARS, NOSE, MOUTH, THROAT

Y N Headaches
Y N Mouth ulcers
Y N Nose bleeds
Y N Dizziness
Y N Hoarseness

NEURO

Y N Muscle weakness
Y N Seizures
Y N Stroke
Y N Loss of sensation
Y N Loss of balance
Y N Speech difficulties

PSYCHIATRIC

Y N Depression
Y N Anxiety
Y N Difficulty sleeping

ALLERGIES/IMMUN.

Y N Food allergies
Y N Seasonal allergies
Y N Allergy shots

Reviewed by: _____

Patient Signature: _____

Date reviewed: _____

Doctor's Initials: _____