ADVANCED SURGICAL ASSOCIATES

PATIENT REVIEW OF SYSTEM

Patient Name: _____ **Date:** _____

PLEASE MARK YES or NO

General:
Fatigue ☐ Yes ☐ No
Fever ☐ Yes ☐ No
Chills ☐ Yes ☐ No
Headache ☐ Yes ☐ No
Weight Loss ☐ Yes ☐ No
Weight Gain ☐ Yes ☐ No

ENT:
Change in Hearing ☐ Yes ☐ No
Chronic Sinus Issues ☐ Yes ☐ No
Throat Pain/Swelling ☐ Yes ☐ No

Cardiovascular:
Chest Pain at Rest ☐ Yes ☐ No
Chest Pain w/Exertion ☐ Yes ☐ No
Arrhythmia ☐ Yes ☐ No
Palpitations ☐ Yes ☐ No
High Blood Pressure ☐ Yes ☐ No
Swelling of Ankles ☐ Yes ☐ No

Respiratory:
Cough ☐ Yes ☐ No
Shortness of Breath ☐ Yes ☐ No
Wheezing ☐ Yes ☐ No

Genitourinary:
Blood in Urine ☐ Yes ☐ No
Frequent Urination ☐ Yes ☐ No
Painful Urination ☐ Yes ☐ No

Musculoskeletal:
Painful Joints ☐ Yes ☐ No
Swollen Joints ☐ Yes ☐ No

Endocrine:
Diabetes ☐ Yes ☐ No
Thyroid Disease ☐ Yes ☐ No

Neurologic:
Weakness ☐ Yes ☐ No
Dizziness ☐ Yes ☐ No
Numbness ☐ Yes ☐ No
Gait Abnormality ☐ Yes ☐ No

HEM/LYMPH:
Easy Bruising/Bleeding ☐ Yes ☐ No
Anemia ☐ Yes ☐ No
Swelling ☐ Yes ☐ No

Skin:
Rash ☐ Yes ☐ No
Skin Lesion ☐ Yes ☐ No
Skin oozing ☐ Yes ☐ No

Optical:
Blurred Vision ☐ Yes ☐ No
Discharge ☐ Yes ☐ No
Redness ☐ Yes ☐ No
Pain ☐ Yes ☐ No

Gastrointestinal:
Abdominal Pain ☐ Yes ☐ No
Nausea ☐ Yes ☐ No
Diarrhea ☐ Yes ☐ No
Vomiting ☐ Yes ☐ No
Constipation ☐ Yes ☐ No
Rectal Bleeding ☐ Yes ☐ No
Rectal Pain ☐ Yes ☐ No
Bloating ☐ Yes ☐ No

Other Complaints: ☐ Yes ☐ No

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