GULFCOAST ORTHOPAEDIC SPECIALISTS, L.L.P.

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Diplomats of the American Board of Orthopaedic Surgery

Review of Systems

Name: ____________________________________ **Date:** _______________

Please Indicate if you are feeling or have had any of the following symptoms in the past?

- ☐ Recent Weight Change
- ☐ Fatigue, Fever

- ☐ Rashes/Unusual Lumps or Sores
- ☐ Itching or Dryness

- ☐ Headache
- ☐ Head Injury
- ☐ Eye Pain
- ☐ Double vision
- ☐ Blurred vision, spots, specks, flashing lights
- ☐ History of glaucoma

- ☐ Ringing in the ears
- ☐ Dizziness
- ☐ Earaches, Infection, Discharge
- ☐ Use of Hearing Aids
- ☐ Recent Colds or Bronchitis
- ☐ Nasal stuffiness, Discharge, Nosebleeds
- ☐ Toothache, Dental Abscess or Sores
- ☐ Sore throat, Hoarseness

  Date of last Dental Exam: ____________________

- ☐ Swollen Glands, Goiter (Thyroid)
- ☐ Cough, History of Chronic Cough, Sputum production
- ☐ Wheezing, Asthma, COPD/Bronchitis, Emphysema
- ☐ History of Pneumonia or tuberculosis pleurisy

  Date of last Chest Exam: ____________________

- ☐ Heart trouble, Chest pain, Palpitations
- ☐ Rheumatic fever, Heart Murmur, Mitral Valve Prolapse
- ☐ History of Angina
- ☐ High Blood Pressure
- ☐ History of Heart Attack (MI)

  Date of Last Stress Test: ____________________

- ☐ Nausea or Vomiting
- ☐ Diarrhea or Abdominal Pain
- ☐ Blood in the stool or History of Colon Cancer
- ☐ History of Hepatitis
- ☐ History of HIV

- ☐ Pain or burning while urinating
- ☐ Blood in the urine
- ☐ History of infection/UTI or Kidney

  Date of last infection: _________________

- ☐ History of BPH

- ☐ Intermittent Claudication or Leg Cramps
- ☐ Blood Clots in the legs/DVT
- ☐ History of Pulmonary Embolism

- ☐ Numbness or Tingling
- ☐ Extremity Weakness or Parathesia
- ☐ Seizures
- ☐ History of TIA or Stroke

If you indicated any of the above, please provide more specific information below. (Date of last evaluation, Acute vs. Chronic problem, Stable vs. Unstable)

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