

Review of Systems

CALIFORNIA PACIFIC ORTHOPAEDICS & SPORTS MEDICINE

Last Name: _____ First Name: _____ Date of Birth: _____

Please check any illness, symptoms or problems that you have had in the last month:

Constitutional

Blood Pressure
Respiration
Fever/sweats
Fatigue
Loss of appetite / weight change

Eyes

Eye Disease of injury
Eye glasses / contact lenses
Blurred / double vision
Glaucoma

Ears / nose / mouth / throat

Hearing loss
Hearing noises in your ear
Earaches and drainage
Nosebleeds
Trouble swallowing
Bleeding gums
Sore throat
Snoring
Voice changes
Problems with thyroid

Musculoskeletal

Joint pain / stiffness
Muscle pain / cramps / weakness
Back pain

Skin

Rashes
Lesions
Ulcers

Cardiovascular

Chest pain / angina
Palpitations
Shortness of breath
Swelling of feet, ankles or hands
Murmur

Respiratory

Cough
Spitting up blood
Shortness of breath
Wheezing

Gastrointestinal

Problems with bowel movements
Nausea / vomiting
Rectal bleeding / blood in stool
Abdominal pain / heartburn

Genitourinary

Flank pain
Problems with urination
Blood in urine
Kidney stone

Neurological

Headaches
Numbness / tingling sensation
Tremors
Head injury

Hematologic / lymphatic

Slow to heal after cuts
Tendency to bleed / bruise
Blood clots
Past blood transfusion

Other Symptoms

Memory loss / confusion
Nervousness / Anxiety
Depression
Insomnia

Completed by: _____ Relationship: _____ Today's Date: _____