St. Clair Health

SCMG - General Surgery
Review of Systems

First Name _____ Last Name _____

DOB ____ / ____ / ____

CONSTITUTIONAL			**GASTROINTESTINAL**		
YES	NO	Recent weight change	YES	NO	Loss of appetite
YES	NO	Fever	YES	NO	Change in bowel movements
YES	NO	Fatigue/tired	YES	NO	Nausea/vomiting
YES	NO	Headaches	YES	NO	Diarrhea
YES	NO	High blood pressure	YES	NO	Constipation
YES	NO	Difficulty sleeping (staying asleep or going to sleep)	YES	NO	Blood in stool or black tarry stool
MUSCULOSKELETAL			YES	NO	Pain in stomach area
YES	NO	Joint pain, stiffness, or swelling	YES	NO	Ever have a colonoscopy? When: Due?_____yrs
YES	NO	Back Pain	**SKIN**		
YES	NO	Bone pain or rib pain	YES	NO	Rash or itching
EAR, NOSE AND THROAT			YES	NO	Change in skin color
YES	NO	Hearing loss	YES	NO	New or changing mole
YES	NO	Nose bleeds	**NEUROLOGIC**		
YES	NO	Mouth sores	YES	NO	Memory loss or confusion
YES	NO	Bleeding gums	YES	NO	Depression
YES	NO	Sore throat	YES	NO	Convulsions or seizures
YES	NO	Swollen glands	YES	NO	Numbness or tingling sensation
YES	NO	Hoarseness/Voice change	YES	NO	Paralysis
EYES			YES	NO	Stroke
YES	NO	Eye disease or injury	**ENDOCRINE**		
YES	NO	Glasses/Contacts	YES	NO	Thyroid disorder
YES	NO	Blurred or double vision	YES	NO	Diabetes ☐ Insulin ☐ Oral hypoglycemic
YES	NO	Glaucoma	YES	NO	Excessive Sweating
RESPIRATORY			YES	NO	Cold intolerance
YES	NO	Frequent coughing	YES	NO	Change in body, facial or head hair
YES	NO	Coughing up blood	**HEMATOLOGIC / COAGULATION**		
YES	NO	Shortness or breath	YES	NO	Bruise easily
YES	NO	Asthma/wheezing	YES	NO	Excessive bleeding with surgery
YES	NO	Tuberculosis	YES	NO	Past transfusion
YES	NO	Snoring or Sleep Apnea	**URINARY**		
YES	NO	Problems with lungs requiring ☐ steroids or ☐ home oxygen	YES	NO	Frequent Urination
CARDIOVASCULAR			YES	NO	Frequent urination at night How many times? _____
YES	NO	Heart trouble	YES	NO	Blood in urine
YES	NO	Chest pain at rest	**GYNECOLOGIC**		
YES	NO	Heart flutter	YES	NO	Regular Menses First day of last period _____
YES	NO	Swollen legs or ankles			Date of last gynecologic exam _____
YES	NO	Difficulty breathing while laying flat			
YES	NO	Leg cramps			
YES	NO	Chest pain with exercise			
YES	NO	Stress test or catheterization | When?			
YES	NO	Do you have a ☐ Pacemaker ☐ Stent ☐ Defibrillator			
YES	NO	Can you walk up a flight (8-12 steps) without difficulty breathing?			

Pharmacy Name: _____

Pharmacy Number: _____

_____

Patient Signature Date