BEND SPINE AND NEUROSURGERY

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Name:______________________________ Date:______________

REVIEW OF SYSTEMS

Check ✔ symptoms experienced in the last 6 months/Circle symptoms for TODAY

CONSTITUTIONAL
_____Fever
_____Chills
_____Weakness/Fatigue
_____Weight loss
_____Weight gain
_____Insomnia
_____Snoring
_____Excessive thirst
_____Excessive urination
_____Cold or heat intolerance

HEENT
_____Sore throat
_____Stiff neck
_____Change in your voice
_____Sinus drainage
_____Sinus headache
_____Nose bleeds
_____Ear ache/drainage
_____Hearing loss
_____Ringing in your ears
_____Blurred vision/loss
_____Wear glasses or contacts
_____Itchy/watery eyes
_____Dental problems

GASTROINTESTINAL
_____Nausea/Vomiting
_____Difficulty swallowing
_____Hemorrhoids
_____Diarrhea
_____Constipation
_____Bloody or black stool
_____Abdominal pain

FEMALE REPRODUCTIVE
_____Hot flashes
_____Bleeding after menopause
_____Excessive menstrual bleeding
_____Unusual vaginal discharge

CARDIAC
_____Chest pain
_____Palpitation
_____Irregular heartbeat
_____Exercise intolerance
_____Leg swelling

RESPIRATORY
_____Persistent cough
_____Coughing up blood
_____Shortness of breath
_____Wheezing
_____Can't breathe lying flat

SKIN
_____Rashes/Hives
_____Skin discoloration
_____Lesions/moles/warts
_____Ulcers
_____Itching
_____Nail problems
_____Unusual hair loss
_____Easy bruising

PSYCH
_____Depressed mood
_____Suicidal thoughts/plans
_____Agitation/irritability
_____Insomnia
_____Anxiety
_____Frequent crying spells

MUSCULOSKELETAL
_____Joint pains or stiffness
_____Joint swelling
_____Muscle weakness
_____Back pain
_____Muscle spasms/cramps
_____Falling

Neurologic
_____Frequent headache
_____Seizures
_____Syncope
_____Limb weakness
_____Limb numbness
_____Dizziness
_____Swallowing difficulty
_____Balance issues
_____Tremors
_____Rigidity

URINARY
_____Pain or burning with urination
_____Urinary frequency
_____Blood in urine/dark urine
_____Incontinence
_____Slow starting/stopping urine

GENITAL/SEX ORGANS
_____Penile discharge
_____Testicular lump/pain
_____Breast pain/discharge/lump
_____Painful intercourse
_____Lack of sexual desire
_____Problems with performance

UNCHANGED WITHIN 6 MONTHS CHECK BOX ☐

INITIAL ________