

# SOMERS ORTHOPAEDIC SURGERY & SPORTS MEDICINE GROUP, P.L.L.C.

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## REVIEW OF SYSTEMS

**Do you have or have you had any of the following within the past year? Please Check All Answers - Whether "Yes" or "No"**

### HEAD & NECK

- Chronic Headaches  No  Yes
- Lumps or Swellings  No  Yes
- Stiff or Painful Neck  No  Yes

### EYES

- Blurred or Double Vision  No  Yes
- Watering or Itchiness of Eyes  No  Yes
- Any Change or Decline in Vision  No  Yes

### EARS

- Earache(s)  No  Yes
- Drainage Discharge from Ear(s)  No  Yes
- Ringing / Noise in ear(s)  No  Yes
- Difficulty Hearing  No  Yes

### NEUROLOGIC

- Frequent Dizziness  No  Yes
- Numbness / Tingling  No  Yes
- Fainting  No  Yes
- Convulsions / Seizures  No  Yes
- Trembling  No  Yes
- Memory Difficulties  No  Yes

### MUSCULOSKELETAL

- Recurrent Back or Neck Pains  No  Yes
- Joint Pains or Problems  No  Yes
- Muscle Pains  No  Yes

### CARDIOVASCULAR / CIRCULATION

- Chest Pain, Tightening or Pressure  No  Yes
- Fast or Irregular Heart Rate  No  Yes
- Leg Cramps on Walking or at Night  No  Yes
- Swelling of Hands, Ankles, or Feet  No  Yes
- High Blood Pressure  No  Yes
- Varicose Veins  No  Yes
- Dizziness or Lightheadedness  No  Yes
- Sleep on Two or more pillows  No  Yes

### RESPIRATORY

- Chronic or Frequent Cough  No  Yes
- Coughed up Blood  No  Yes
- Shortness of Breath  No  Yes
- Wheezing or Asthma  No  Yes

### CONSTITUTIONAL

- Recent Weight Change  No  Yes
- Recurrent Fevers  No  Yes
- Fatigue  No  Yes

### MOUTH

- Taste Changes  No  Yes
- Sore Tongue, Sore or Swollen Gums  No  Yes
- Dental Problems  No  Yes

### NOSE / THROAT

- Frequent Colds Or Sneezing  No  Yes
- Nose Bleeds  No  Yes
- Difficulty Swallowing  No  Yes
- Hoarseness of Voice  No  Yes
- Broken Nose or Deviated Septum  No  Yes
- Snoring  No  Yes

### DIGESTIVE

- Nausea or Vomiting  No  Yes
- Heartburn  No  Yes
- Vomiting of Blood  No  Yes
- Diarrhea  No  Yes
- Constipation  No  Yes
- Pain w/ Stool or Rectum  No  Yes
- Gray or Black Stools  No  Yes
- Blood in Stool or Rectum  No  Yes
- Charge in Bowel HABits  No  Yes
- Excess Gas, Bloating  No  Yes
- Hemorrhoids  No  Yes

### GENITOURINARY

- Painful or Burning  No  Yes
- Frequent or Nocturnal Urination  No  Yes
- Difficulty Starting or Stopping Urination  No  Yes
- Loss of Control or Dribbling of Urine  No  Yes
- Brown or Bloody Urine  No  Yes
- Prostate Problems (Men only)  No  Yes

### WOMEN ONLY: MENSTRUAL HISTORY

- Date of Last Menstrual Period \_\_\_\_\_
- Pregnancy  No  Yes

### ENDOCRINE

- Excessive Thirst or Urination  No  Yes
- Inability to Tolerate Heat or Cold  No  Yes
- Change in Skin or Hair Texture  No  Yes

### SKIN

- Rashes or Lesions  No  Yes
- Dry, Itchy Skin  No  Yes
- Changes in Warts or Moles  No  Yes
- Bruises Easily  No  Yes
- Other Skin Problems  No  Yes