

REVIEW OF SYSTEMS-LAKE COOK ORTHOPEDICS

DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS? CIRCLE YES OR NO ON EACH ONE

PATIENT NAME: _____

PLEASE DO NOT CIRCLE YES OR NO IN GROUPS

ALLERGIC:

- 1. FREQUENT INFECTIONSYesNo
- 2. METAL ALLERGIESYesNo
- 3. SHELLFISH ALLERGIESYesNo
- 4. IODINE ALLERGYYesNo
- 5. LATEX ALLERGYYesNo
- 6. ANAPHYLACTIC REACTIONYesNo

CARDIOVASCULAR

- 7. CHEST PAINYesNo
- 8. RAPID HEART BEAT AT RESTYesNo
- 9. ANKLE SWELLINGYesNo
- 10. HIGH CHOLESTEROLYesNo
- 11. HEART MURMURYesNo
- 12. IRREGULAR HEARTBEATSYesNo
- 13. PAIN IN CALVES WITH WALKINGYesNo
- 14. VARICOSE VEINSYesNo
- 15. CALF CRAMPING AT NIGHTYesNo

CONSTITUTIONAL

- 16. FATIGUEYesNo
- 17. LOSS OF APPETITEYesNo
- 18. WEIGHT LOSSYesNo
- 19. FEVERYesNo
- 20. ACHE ALL OVERYesNo
- 21. SLEEP PROBLEMSYesNo

EAR, NOSE, THROAT

- 22. DIFFICULTY WITH HEARINGYesNo
- 23. RINGING IN THE EARSYesNo
- 24. FREQUENT BLOODY NOSESYesNo
- 25. SINUS PROBLEMSYesNo
- 26. LOSS OF SENSE OF SMELLYesNo
- 27. SORES IN MOUTHYesNo
- 28. INFECTED TEETHYesNo
- 29. BLEEDING GUMSYesNo
- 30. HOARSENESSYesNo
- 31. DIFFICULTY SWALLOWINGYesNo
- 32. SORE THROATYesNo
- 33. SWOLLEN GLANDSYesNo
- 34. SNORINGYesNo

ENDOCRINE

- 35. POOR HEALINGYesNo
- 36. EXCESSIVE APPETITEYesNo
- 37. HOT FLASHESYesNo
- 38. EXTREME THIRSTYesNo
- 39. EXCESSIVE HAIR GROWTHYesNo

EYES

- 40. BLURRED VISIONYesNo
- 41. DOUBLE VISIONYesNo
- 42. ABRUPT LOSS OF VISIONYesNo
- 43. GLASSESYesNo

GASTROINTESTINAL

- 44. PAIN IN STOMACHYesNo
- 45. DIARRHEAYesNo
- 46. NAUSEAYesNo
- 47. VOMITINGYesNo
- 48. BLOOD IN STOOLSYesNo
- 49. LOSS OF CONTROL OF BOWELSYesNo
- 50. DARK BLACK STOOLSYesNo

GENITOURINARY

- 51. IMPOTENCEYesNo
- 52. NEED TO URINATE OFTENYesNo
- 53. VAGINAL/PENILE DISCHARGEYesNo
- 54. BLOOD IN URINEYesNo
- 55. BURNING WITH URINATIONYesNo
- 56. LOSS OF CONTROL OF URINEYesNo

HEMATOLOGIC

- 57. EASY BRUISINGYesNo
- 58. BLEEDING PROBLEMSYesNo
- 59. SICKLE CELL DISEASEYesNo
- 60. ANEMIAYesNo
- 61. PREVIOUS BLOOD TRANSFUSIONSYesNo

INTEGUMENTARY

- 62. ACNEYesNo
- 63. BLISTERSYesNo
- 64. RASHESYesNo
- 65. PSORIASISYesNo
- 66. EXCESSIVE SCARRINGYesNo
- 67. SHINGLESYesNo

NEUROLOGICAL

- 68. HEADACHESYesNo
- 69. DIZZINESSYesNo
- 70. NUMBNESSYesNo
- 71. WEAKNESSYesNo
- 72. FORGETFULNESSYesNo
- 73. FAINTINGYesNo
- 74. TREMORSYesNo

PSYCHIATRIC

- 75. INSOMNIAYesNo
- 76. DEPRESSIONYesNo
- 77. SUICIDALYesNo
- 78. ADDICTION DISEASEYesNo
- 79. PANIC ATTACKSYesNo
- 80. VICTIM OF ABUSEYesNo
- 81. EATING DISORDERYesNo

RESPIRATORY

- 82. SHORTNESS OF BREATHYesNo
- 83. CHRONIC COUGHYesNo
- 84. COUGHING UP BLOODYesNo
- 85. SLEEP APNEAYesNo
- 86. SHORT OF BREATH WHEN LYING FLATYesNo

DATE: _____

X _____

Patient signature

PHYSICIAN INITIALS AND DATE: _____

Initials signify review of the data with the patient and agreement with the data.

