North Dallas Plastic Surgery Associates

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REVIEW OF SYSTEMS

Name _____ Date _____

Please CIRCLE any of the following conditions that apply to you

General: weight changes fatigue fever chills

Eyes: eye pain excessive tearing visual changes double vision eye irritation dry eyes red eyes glaucoma contact lenses sensitivity to light

Ears: ear pain ringing in the ears dizziness hearing loss

Nose: past nasal trauma past nasal surgery difficulty breathing through nose sinus problems

Mouth: dental problems tooth pain difficulty swallowing oral cancers dentures capped teeth

Cardiovascular: high blood pressure heart attacks heart surgery irregular heartbeat murmur chest pain congestive heart failure foot swelling Rheumatic fever pacemaker

Respiratory: asthma shortness of breath bronchitis pneumonia recent cough TB

Gastrointestinal: peptic ulcers reflux indigestion vomiting diarrhea constipation blood in stools Black stools change in bowel habits hepatitis jaundice liver cirrhosis

Genitourinary: urinary tract infections yeast infections difficulty urinating frequent urination STD

Musculoskeletal: injuries swelling extremity pain joint pain arthritis leg cramps difficulty walking

Neurologic: seizures stroke dizziness sensory loss weakness

Psychiatric: depression alcoholism drug abuse anxiety marital problems

Hematologic: Bleeding disorders anemia easy bruising bleeding gums swollen lymph nodes

Immunologic: HIV high risk behavior transfusions

Endocrine: diabetes thyroid disorder hypoglycemia adrenal disorders

Skin Disease: rashes new or changing lesions skin cancers

Allergic: food allergies latex allergies steroid use environmental allergies

Women's Health: Pregnancies _____ Live Births _____ Miscarriages/Abortions _____

Last menstrual period _____ Are you pregnant? Yes No

Last Mammogram _____ result _____

Drug Use: Diet aides Aspirin Herbal remedies Blood thinners Steroids Chemotherapy

MD Initial _____