

The Steadman Clinic: Review of Systems

First Name: _____
 Last Name: _____

DOB: _____
 Today's Date: _____

Please check all that apply:

Symptom	Yes	Symptom	Yes	Symptom	Yes
Arthritis		Loss of vision		Sore throat	
Joint stiffness		Eye infection (iritis)		Dental problems	
Muscle aches		Glasses		Difficulty swallowing	
Joint swelling		Contacts		Nasal stuffiness/discharge	
Instability		Eye pain		Nose bleeds	
Muscle weakness		Eye redness		Ear ache or infection	
Headaches		Vision change		ringing in ears	
Numbness, tingling, loss of sensation		Cataracts		Hoarseness	
Dizziness		Glaucoma		Decreased or loss of hearing	
Poor balance		Easy bruising		Heartburn	
Fainting spells		Easy bleeding		Vomiting	
Seizures		Varicose veins		Nausea	
Weight gain		Blood clots		Abdominal pain	
Weight loss		Anemia		Acid reflux	
Chills		Hay fever		Frequent infection of urine	
Fever		Environmental allergies		Reduced flow of urine	
Weakness/fatigue		Hives		Pneumonia or Bronchitis	
Change or loss of appetite		HIV exposure		Wheezing/asthma	
Night sweats		Seasonal allergy		Frequent cough	
Ulcers/sores		Chest pain		Depression	
Rash		Swelling in legs		Nervousness	
Itching		Shortness of breath		Anxiety	
Abnormal scars		Palpitations		Mood swings	
Redness		Excessive thirst or hunger		Height: _____ Weight: _____	
Psoriasis		Hot/cold intolerance			
Blurred vision		Hot flashes			

Alert	Yes
Blood thinners	
Defibrillator	
Premedication prior to procedures	
Rheumatoid Arthritis	
RSD/CRPS	
Allergy to shellfish/iodine	
Allergy to latex	
Allergy to adhesive	
Under pain management	
Pregnancy or planning pregnancy	
Cardiac pacemaker	
Brain vessel clips	
Aortic clips	
Heart valve/stents	
Insulin pump or other drug pump	
TENS unit or pain stimulation unit	
Hearing aids, cochlear, otologic or other ear implants	
Metal fragments in head, eye or skin	
Neurostimulator	
Tissue expander (breast)	
Bladder stimulator	
A-fib	
Malignant hypothermia	
Bleeding disorder	
Prior anesthesia issues	
History of MRSA	