FAIRVIEW SOUTHDALE HOSPITAL

Patient Name _____

Date of Birth _____

REVIEW OF SYSTEMS

CARDIOVASCULAR	YES	NO
HEART ATTACK	☐	☐
HEART TROUBLE OR RHEUMATIC FEVER	☐	☐
CONGESTIVE HEART FAILURE	☐	☐
RACING HEART OR MISSED BEAT	☐	☐
CHEST PAIN	☐	☐
MITRAL VALVE PROLAPSE	☐	☐
MURMUR	☐	☐
SWOLLEN FEET OR ANKLES	☐	☐
BLOOD CLOTS IN LEGS	☐	☐
HIGH BLOOD PRESSURE	☐	☐
BLEEDING TENDENCIES	☐	☐
ANEMIA	☐	☐
SICKLE CELL	☐	☐
EXCESSIVE PERSPIRATION	☐	☐
PERIPHERAL VASCULAR DISEASE	☐	☐

RESPIRATION		
EMPHYSEMA	☐	☐
ASTHMA	☐	☐
PNEUMONIA, BRONCHITIS	☐	☐
TUBERCULOSIS	☐	☐
SHORTNESS OF BREATH	☐	☐
RECENT COLD, FLU, SORE THROAT	☐	☐
PULMONARY EMBOLISM	☐	☐
HOME OXYGEN	☐	☐
SLEEP APNEA	☐	☐

NEURO		
FAINTING SPELLS	☐	☐
DIZZINESS	☐	☐
FREQUENT HEADACHES	☐	☐
HEAD INJURY	☐	☐
SEIZURES/EPILEPSY	☐	☐
NUMBNESS/TINGLING	☐	☐
WEAKNESS/PARALYSIS _____	☐	☐
MULTIPLE SCLEROSIS _____	☐	☐
STROKE	☐	☐

GU		
FREQUENT URINARY TRACT INFECTIONS	☐	☐
INCONTINENCE BLOOD IN URINE	☐	☐
KIDNET STONES	☐	☐
KIDNEY DISEASE	☐	☐
DIALYSIS _____	☐	☐
PROSTATE PROBLEMS	☐	☐

GI		
DIARRHEA CONSTIPATION	☐	☐
BLOOD IN STOOL	☐	☐
POLYPS	☐	☐
FAMILY HISTORY POLYPS/COLON CANCER	☐	☐
ULCERATIVE COLITIS/CHRONIC DISEASE	☐	☐
OSTOMY	☐	☐

NUTRITION/METABOLIC	YES	NO
DIABETES	☐	☐
HYPOGLYCEMIA	☐	☐
PANCREATITIS	☐	☐
HIATAL HERNIA	☐	☐
RECENT WEIGHT GAIN/LOSS	☐	☐
ULCERS	☐	☐
MOTION SICKNESS	☐	☐
FREQUENT NAUSEA/VOMITING	☐	☐
HEPATITIS/LIVER DISEASE	☐	☐
THYROID	☐	☐
ADRENAL,ADDISONS OR CUSHINGS DISEASE	☐	☐
SPECIAL DIET	☐	☐
TYPE _____	☐	☐

ACTIVITY/EXERCISE PATTERN		
LIMITS/INTOLERANCES TO ACTIVITY OR EXERCISE	☐	☐
WHAT _____		
ARTHRITIS	☐	☐
LOCATION _____		
MISSING LIMBS	☐	☐
PROSTHESIS	☐	☐
BACK PROBLEMS	☐	☐
LIMITATIONS IN MOVEMENT	☐	☐

GOGNITIVE/PERCEPTUAL		
VISION PROBLEMS	☐	☐
SPECIFY _____		
GLAUCOMA	☐	☐
GLASSES/CONTACTS	☐	☐
HEARING PROBLEMS	☐	☐
SPECIFY _____		
HEARING AIDE R ☐ L ☐	☐	☐
DENTURES/PARTIALS U☐ L ☐	☐	☐
LOOSE TEETH	☐	☐

PSYCHOSOCIAL		
SMOKER _____ PACK/DAY _____ YEARS_____		
QUIT DATE _____		
RECREATION/STREET DRUGS	☐	☐
ALCOHOL	☐	☐
ADVANCED DIRECTIVES/LIVING WILL	☐	☐

SEXUAL/REPRODUCTIVE		
PREGNANT	☐	☐
DATE OF LAST MENSTRUAL PERIOD _____		
HISTORY OF SEXUALLY TRANSMITTED DISEASES	☐	☐

COPING/STRESS/SELF PERCEPTION/RELATIONSHIP

Is there any significant change in your life recently? ☐ ☐

Please explain _____

_____

Do you have any special spiritual, cultural or religious needs to be considered? NO ☐ YES ☐ _____

_____

Who is your support person? _____

PATIENT SIGNATURE _____ **DATE** _____