SHSG REVIEW OF SYSTEMS

☐ Male ☐ Female Height ___________ Weight ___________

Office Use Only
Temp ___________

Reason for Visit ____

Prior Surgeries and Hospitalizations:

____
____
____
____
____

Current Medications:

____
____
____
____
____

Surgical Issues (check all that apply)

☐ Anesthesia problems (you or a close relative)
☐ Bleeding disorder or on a blood thinner
☐ Loose / removable dental work
☐ Pregnant / possibly pregnant
☐ Objection to blood transfusion
☐ Nausea following anesthesia
☐ Contact lenses
☐ Reflux or heartburn
☐ Sleep apnea
☐ **None**

Comments: ____

Allergies (medications, LATEX or other): Please indicate the reaction (e.g. hives, rash, difficulty breathing) ☐ **No allergies**

____ ____
____ ____

			Comments
Head and Neck			
☐ Yes	☐ No	Jaw pain (TMJ pain)	__________________________________
☐ Yes	☐ No	Neck stiffness	__________________________________
Respiratory			
☐ Yes	☐ No	Smoker	__________________________________
☐ Yes	☐ No	Shortness of breath	__________________________________
Cardiovascular			
☐ Yes	☐ No	High blood pressure	__________________________________
☐ Yes	☐ No	Stroke	__________________________________
☐ Yes	☐ No	Coronary artery disease (angina, prior heart attack)	__________________________________
☐ Yes	☐ No	Congestive heart failure	__________________________________
☐ Yes	☐ No	Irregular rhythm	__________________________________
☐ Yes	☐ No	Heart murmur	__________________________________
☐ Yes	☐ No	Peripheral vascular disease	__________________________________
Gastrointestinal/Renal			
☐ Yes	☐ No	Ulcers	__________________________________
☐ Yes	☐ No	Liver problems	__________________________________
☐ Yes	☐ No	Kidney failure	__________________________________
Musculoskeletal			
☐ Yes	☐ No	Arthritis	__________________________________
☐ Yes	☐ No	Osteoporosis/osteopenia	__________________________________
☐ Yes	☐ No	Artificial joints	__________________________________
Neurologic			
☐ Yes	☐ No	Seizures	__________________________________
☐ Yes	☐ No	Paralysis	__________________________________
Metabolic			
☐ Yes	☐ No	Diabetes	__________________________________
☐ Yes	☐ No	Thyroid disease	__________________________________
Infectious Disease			
☐ Yes	☐ No	HIV	__________________________________
☐ Yes	☐ No	Hepatitis (B,C)	__________________________________
☐ Yes	☐ No	MRSA (past or present)	__________________________________
☐ Yes	☐ No	Immunizations up to date (Patients under 18 only)	__________________________________
Social			
☐ Yes	☐ No	Alcohol or recreational drugs	__________________________________

Office Use Only

Reviewed by MD

Sig _________________
Date ____/____/_____

Reviewed by MD

Sig _________________
Date ____/____/_____

Reviewed by patient
☐ No changes from prior
☐ Changes noted
Date ____/____/_____

Reviewed by patient
☐ No changes from prior
☐ Changes noted
Date ____/____/_____

Reviewed by patient
☐ No changes from prior
☐ Changes noted
Date ____/____/_____