REVIEW OF SYSTEMS

Patient Name

Date of Birth

Patient #

BAY STREET
ORTHOPAEDICS & SPINE

Do you now or have you had any problems related to the following in the past year?

If you answered Yes to ANY of the above, we recommend seeing your Primary Care Provider or Specialist.

PRIMARY PROVIDER

PHYSICIAN SIGNATURE

DATE

Constitutional Symptoms		
Fever	☐ Yes	☐ No
Chills	☐	☐
Headache	☐	☐
Other	☐	☐
Eyes		
Blurred Vision	☐ Yes	☐ No
Double Vision	☐	☐
Pain	☐	☐
Other	☐	☐
Allergic/Immunologic		
Hay Fever	☐ Yes	☐ No
Drug Allergies	☐	☐
Other	☐	☐
Neurological		
Tremors	☐ Yes	☐ No
Dizzy Spells	☐	☐
Numbness/Tingling	☐	☐
Other	☐	☐
Endocrine		
Excessive Thirst	☐ Yes	☐ No
Too Hot/Cold	☐	☐
Tired/Sluggish	☐	☐
Other	☐	☐
Gastrointestinal		
Abdominal Pain	☐ Yes	☐ No
Nausea/Vomiting	☐	☐
Indigestion/Heartburn	☐	☐
Other	☐	☐
Cardiovascular		
Chest Pain	☐ Yes	☐ No
Varicose Veins	☐	☐
High Blood Pressure	☐	☐
Other	☐	☐

Integumentary		
Skin Rash	☐ Yes	☐ No
Boils	☐	☐
Persistent Itch	☐	☐
Other	☐	☐
Musculoskeletal		
Joint Pain	☐ Yes	☐ No
Neck Pain	☐	☐
Back Pain	☐	☐
Other	☐	☐
Ear/Nose/Throat/Mouth		
Ear Infection	☐ Yes	☐ No
Sore Throat	☐	☐
Sinus Problem	☐	☐
Other	☐	☐
Genitourinary		
Urine Retention	☐ Yes	☐ No
Painful Urination	☐	☐
Urinary Frequency	☐	☐
Other	☐	☐
Respiratory		
Wheezing	☐ Yes	☐ No
Frequent Cough	☐	☐
Shortness of Breath	☐	☐
Other	☐	☐
Hematologic/Lymphatic		
Swollen Glands	☐ Yes	☐ No
Blood Clotting Problem	☐	☐
Other	☐	☐
Psychological		
Do you feel anxious?	☐ Yes	☐ No
Do you feel depressed?	☐	☐