ABDOMINAL SPECIALISTS OF SOUTH TEXAS

REVIEW OF SYSTEMS

NAME: **DOB:** **DATE:**

CONSTITUTION			**MUSCULOSKELETAL**		
Fever	Yes	No	Back Pain	Yes	No
Weight Gain	Yes	No	Joint Pain	Yes	No
EYES			**DERMATOLOGICAL**		
Blurred Vision	Yes	No	Itching	Yes	No
Jaundice	Yes	No	Rash	Yes	No
EAR/NOSE/THROAT			Tattoo	Yes	No
Nose bleeds	Yes	No	**NEUROLOGICAL**		
CARDIAC			Seizure	Yes	No
Chest Pain	Yes	No	Stroke/CVA	Yes	No
Dizziness	Yes	No	**PSYCHIATRIC**		
Edema	Yes	No	Depression	Yes	No
RESPIRATORY			Feeling stressed	Yes	No
Cough	Yes	No	Recreational Drug use	Yes	No
Shortness of Breath	Yes	No			
TB Exposure	Yes	No	**HEMATOLOGICAL**		
ALLERGY/ IMMUNOLOGY			Excessive Bleeding	Yes	No
HIV	Yes	No	Previous transfusions	Yes	No
Seasonal Allergies	Yes	No			

GASTROINTESTINAL

Abdominal pain	Yes	No	Loss of appetite	Yes	No
Bloating	Yes	No	Change in bowels	Yes	No
Diarrhea	Yes	No	Difficulty swallowing	Yes	No
Heartburn	Yes	No	Vomiting Blood	Yes	No
Hemorrhoids	Yes	No	Hepatitis	Yes	No
Black Stools	Yes	No	Nausea	Yes	No
Painful swallowing	Yes	No	Vomiting	Yes	No

IF YOU HAVE ANY QUESTIONS, PLEASE ASK THEM OF THE **MA ROOMING** YOU, **NOT THE FRONT DESK STAFF**.