GSA
GENERAL SURGERY
— ASSOCIATES —

REVIEW OF SYSTEMS

Patient Name: _____ Date: _____

PLEASE CIRCLE THE APPROPRIATE ANSWER TO THE FOLLOWING CONDITIONS THAT YOU MIGHT BE EXPERIENCING:

Y / N Fevers

Y / N Night Sweats

Y / N Weight Loss/Weight Gain

Y / N Vision Changes

Y / N Hearing Loss

Y / N Nose Bleeds

Y / N Sinus Problems

Y / N Sore Throat

Y / N Chest Pain

Y / N Heart Palpitations

Y / N Heart Murmur

Y / N Pacemaker/Defibrillator

Y / N Shortness of Breath

Y / N Cough

Y / N Sleep Apnea

Y / N Abdominal Pain

Y / N Nausea/Vomiting

Y / N Diarrhea

Y / N Constipation

Y / N Gastroesophageal Reflux Disease (GERD)

Y / N Incontinence

Y / N Blood in Urine

Y / N Muscle Aches

Y / N Muscle Weakness

Y / N Rheumatoid Arthritis

Y / N Gout

Y / N Swelling of the Hands or Feet

Y / N Abnormal Skin Lesions

Y / N Psoriasis

Y / N Jaundice

Y / N Seizures

Y / N Headaches/Migraines

Y / N Dizziness

Y / N Anxiety

Y / N Depression

Y / N Swollen Glands

Y / N Bruising