NYU Langone Health

Review of Systems

Patient Name: _____ ***Date of Birth:*** _____ ***Today's Date:*** _____

Please complete the following and return with your registration form. Answer yes to any current condition or condition that you have had in the past.

CONSTITUTIONAL	**Yes**	**No**
Weight Change > 10lbs.	☐	☐
Fever	☐	☐
Sweats	☐	☐
Fatigue	☐	☐
EYES		
Glaucoma	☐	☐
Cataracts	☐	☐
Vision Surgery	☐	☐
EARS, NOSE, THROAT		
Loss of Hearing	☐	☐
Dizziness	☐	☐
Nose Bleeding	☐	☐
Gum Bleeding	☐	☐
RESPIRATORY		
Chronic Cough	☐	☐
Bronchitis	☐	☐
Shortness of Breath	☐	☐
Asthma	☐	☐
Pneumonia	☐	☐
CARDIOVASCULAR		
Heart Attack	☐	☐
Chest Pain/Angina	☐	☐
Heart Murmur	☐	☐
Anemia	☐	☐
Transfusions	☐	☐
Phlebitis or Blood Clots	☐	☐
Rheumatic Fever	☐	☐
Heart Surgery	☐	☐
GASTROINTESTINAL		
Reflux	☐	☐
Hepatitis A	☐	☐
Blood in Stools	☐	☐
Diarrhea/Constipation	☐	☐
Hernia/Repair	☐	☐
Gall Bladder	☐	☐
ENDOCRINE		
Diabetes	☐	☐
Thyroid Problem	☐	☐
Hormone Treatment	☐	☐

BREAST	**Yes**	**No**
Masses	☐	☐
Breast Surgery	☐	☐
URINARY SYSTEM		
Urinary Tract/Bladder Infection	☐	☐
Kidney stone(s)	☐	☐
Incontinence	☐	☐
Trouble urinating	☐	☐
GENITAL		
Pelvic Infection	☐	☐
Pelvic Surgery	☐	☐
Pelvic Pain	☐	☐
Endometriosis	☐	☐
SKIN		
Cancer(s)	☐	☐
Rashes	☐	☐
NEUROLOGIC		
Stroke	☐	☐
Seizures	☐	☐
Head Injury	☐	☐
Nerve Damage	☐	☐
PSYCHIATRIC		
Depression	☐	☐
Anxiety	☐	☐
Substance Abuse	☐	☐
MUSCULOSKELETAL		
Osteoarthritis	☐	☐
Rheumatoid Arthritis	☐	☐
Gout	☐	☐

COMMENTS:

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