JORGE L. RINCON MD, FACS

Review of Systems

Check Yes or No to the Following

Constitutional Symptoms:			Neurological:		
Yes	**No**		**Yes**	**No**	
☐	☐	Fever	☐	☐	Frequent Headaches
☐	☐	Sweats	☐	☐	Convulsions / seizures
☐	☐	Chills	☐	☐	Numbness
☐	☐	Weight Loss	☐	☐	Stroke
☐	☐	Fatigue	☐	☐	Dizziness
☐	☐	Weakness	☐	☐	Weakness (focal)
Eyes:			**Gynecological:**		
Yes	**No**		**Yes**	**No**	
☐	☐	Blurred/ double vision	☐	☐	Hysterectomy
☐	☐	Cataracts	☐	☐	Vaginal Bleeding / spotting
☐	☐	Drainage from Eyes	☐	☐	Painful Intercourse
☐	☐	Glaucoma			
☐	☐	Eye Pain	_____ # of pregnancies		
☐	☐	Lasik (eye correction)	_____ Last Menstrual Period/ Age____		
Ears/Nose/Mouth/Throat:			**Gastrointestinal:**		
Yes	**No**		**Yes**	**No**	
☐	☐	Hearing Loss	☐	☐	Reflux / Acidity
☐	☐	Ear pain	☐	☐	Loss of Appetite
☐	☐	Nose Bleeding	☐	☐	Abdominal Pain
☐	☐	Bleeding Gums	☐	☐	Nausea / Vomiting
☐	☐	Swollen Glands	☐	☐	Constipation
☐	☐	Sore Throat	☐	☐	Diarrhea
☐	☐	Difficulty Swallowing	☐	☐	Blood in Stool
			☐	☐	Gallstones
Cardiovascular:			**Respiratory:**		
Yes	**No**		**Yes**	**No**	
☐	☐	Heart Disease	☐	☐	**A**sthma
☐	☐	Bypass	☐	☐	Phlegm
☐	☐	Hypertension (high blood pressure)	☐	☐	Coughing
☐	☐	Chest Pain	☐	☐	Coughing Blood
☐	☐	Pacemaker	☐	☐	Shortness of Breath
Genitourinary:			**Endocrine:**		
Yes	**No**		**Yes**	**No**	
☐	☐	Frequent Urination	☐	☐	Diabetes
☐	☐	Painful Urination	☐	☐	Thyroid
☐	☐	Blood in Urine	☐	☐	Heat / Cold Intolerance
☐	☐	Kidney Stones/Bladder Stones	☐	☐	Swollen Glands
Musculoskeletal:			**Skin:**		
Yes	**No**		**Yes**	**No**	
☐	☐	Back Pain	☐	☐	Breast Lump
☐	☐	Joint Pain or Swelling	☐	☐	Breast Pain
☐	☐	Muscle Weakness	☐	☐	Breast Discharge
☐	☐	Arthritis	☐	☐	Skin Rash / Lesions
Psychiatric:			**Male:**		
Yes	**No**		**Yes**	**No**	
☐	☐	Memory Loss	☐	☐	Testicle Pain
☐	☐	Depression	☐	☐	Discharge from Penis
			☐	☐	Erectile Dysfunction

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Review of Systems

Check Yes or No to the Following

HEMATOLOGIC/LYMPHATIC		
Yes	No	
☐	☐	Anemia
☐	☐	Bruising Tendency
☐	☐	Bleeding Tendency
☐	☐	Thrombosis (Blood clots in arms/legs)

List all Surgeries You have had and When:
List any INJURIES or ILLNESSES or HOSPITALIZATIONS:
List any ALLERGIES:
List ALL MEDICATIONS including dosage:
List any CANCER or MEDICAL problems in your family:

Name of patient/ person filling out form **Relationship**

Date