# SYSTEMS REVIEW

As you review the following, please CHECK any of those problems which apply to you.

## GENERAL
- Recent weight loss/amount
- Recent weight gain/amount
- Fatigue
- Weakness
- Fever
- Diet Pills

## HEART & LUNGS
- Pain in chest
- Irregular heart beat
- Sudden changes in heart rate
- Shortness of breath
- Difficulty breathing at night
- Swollen legs or feet
- High blood pressure
- Heart murmurs
- Cough
- Coughing of blood
- Wheezing
- Night sweats
- Pacemaker
- Defibrillator
- Heart Attack
- Stroke

## BLOOD
- Anemia
- Bleeding tendency

## SKIN
- Easy bruising
- Redness
- Rash
- Hives
- Sun sensitive (sun allergy)
- Tightness
- Nodules/bumps
- Hair loss
- Color changes of hands or feet in the cold

## MUSCLES/JOINTS/BONES
- Morning stiffness
  - Lasting how long:
    - minutes
    - hours
- Joint pain
- Muscle weakness
- Muscle tenderness
- Joint swelling

Please list any complications that are not listed above:

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## PHYSICIAN SIGNATURE

Physician Signature

Date: ____________________________

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