Specialty: General Surgery **Visit Types:** New pt visit
Est pt visit

General Surgery Review of Systems

Please answer every question

Compatible Note Forms: CHI Adult Female ROS – Gen Surg CHI Adult Male ROS – Gen Surg

PLEASE PRINT PATIENT'S LAST NAME																
Marking Instructions																
Please use a #2 pencil.		PATIENT'S FIRST NAME					MIDDLE INITIAL		PATIENT'S DATE OF BIRTH							
Fill in the complete oval as shown																
												_				

Please mark all symptoms you are <u>CURRENTLY</u> experiencing. Mark all that apply. If you have no symptoms in a category, please mark "NONE."

CONSTITUTIONAL	fever difficulty sleeping fatigue	chills weight loss weight gain	NONE (
EYES		vision problems 🔘	NONE						
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EAR / NOSE / THROAT	sinus problems 🔾	loss of hearing	NONE _						
a a a a a a a a a a a a a a a a a a a	chest pain	anemia 🔾							
CARDIOVASCULAR	blood clots ankle swelling	phlebitis Obleeding problems	NONE						
		cough 🔾							
RESPIRATORY	shortness of breath	asthma	NONE _						
GASTROINTESTINAL	change in bowel habits nausea vomiting blood in stool hemorrhoids	peptic ulcer difficulty or discomfort in swallowing constipation colitis hiatal hernia diarrhea	NONE (
GENITOURINARY	Tienormolas C	painful urination	NONE O						
NEUROLOGICAL	headache 🔾	seizures 🔾	NONE						
please fold on dotted line									
MUSCULOSKELETAL	joint pain 🔾	back pain arthritis	NONE O						
PSYCHIATRIC	anxiety 🔘	depression Chemical dependency	NONE						