ColumbiaDoctors | *Neurological Surgery*

Patient Name: _____ **Unit #:** _____

Review of Systems	**Please check (x) if any of the following apply to you now, in the past, or often.**		
	Yes	**No**	**Notes**
Current weight: _____			
Height: _____			
weight loss/weight gain			
fever			
fatigue			
Eyes			
double vision			
spots before eyes			
vision changes			
dry eyes			
glaucoma/cataracts			
Ent/Mouth			
ear aches			
ringing in ears			
sinus problems			
sore throat			
mouth sores			
dental problems			
difficulty swallowing			
Cardiovascular			
painful breathing			
chest pain or shortness of breath			
atrial fibrillation or irregular heartbeat			
swelling of legs			
high cholesterol			
high blood pressure			
heart murmur/heart failure			
heart attack or angina			
Respiratory			
shortness of breath/ swollen ankles			
wheezing/cough			
spitting up blood			
tuberculosis (tb)			
smoked in the last year			

Patient Name: _____ **Unit #:** _____

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Gastrointestinal	**Yes**	**No**	**Notes**
severe abdominal pain			
diarrhea			
bloody stool			
nausea/vomiting			
constipation			
Genitourinary			
blood in urine			
painful urination			
urgency/frequency			
incomplete emptying			
painful intercourse			
For Females			
abnormal periods			
last menstrual cycle			
Musculoskeletal/Neurological			
muscle weakness			
trouble walking			
swelling			
stroke or seizures			
head, neck, or back injuries			
chronic pain			
"pins and needles" feeling			
loss of sensation/numbness			
headaches			
dizziness			
Psychiatric			
depression/anxiety			
psychiatric disorder			
sleep problems			
Endocrine/Renal			
dry skin			
abnormal thirst			
hot flashes			
diabetes			
adrenal or thyroid disease			
kidney disease/failure			
hepatitis/jaundice/cirrhosis			
Hematologic/Lymphatic			
anemia/low blood count			
bleeding ulcers			
sickle cell disease			

Patient Name: _____ **Unit #:** _____

bruises, frequent			
enlarged lymph nodes			

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Allergic/Immunologic	**Yes**	**No**	**Notes**
allergies			
drugs, other			
Skin			
new rashes/skin lesions			
Other Personal History			

Operations/ Hospitalizations

Reason	Date	Reason	Date

Injuries/Illnesses

Type	Date

Current Medications

Drug name	Dosage

Patient Name: _____ **Unit #:** _____

Drug name	Dosage

Family History

Illness	Yes	Relative	Illness	Yes	Relative
diabetes			drinking		
stroke			breast cancer		
heart disease			colon cancer		
high blood pressure			ovarian cancer		
aneurysm			other		

Social History

Habits			
smoking	yes ___ no ___	packs per day _____	years _____
alcohol	yes ___ no ___	drinks per day _____	years _____
drug use	yes ___ no ___		

Personal Profile

marital status: married ___ single ___ widowed ___ divorced ___ number of children____

occupation: _____ education: _____

other: _____

Signature of patient: _____ **Date:** _____

Date reviewed by patient: _____

Physician signature: _____ **Date:** _____