

THE CENTER
FOR LUNG AND
CHEST SURGERY



102 PARK STREET • GLENS FALLS, NY 12801 • (518) 926-5864 • WWW.GLENSFALLSLUNGANDCHESTSURGERY.COM

REVIEW OF SYSTEMS

Name: _____ Date of Birth: _____

Do you now or have you had any problems related to the following systems?

Circle Yes or No. Please explain Yes answers in the space provided.

CONSTITUTION SYMPTOMS

Fever	Yes	No
Chills	Yes	No
Weight Loss	Yes	No
Night Sweats	Yes	No
Other	_____	

SKIN

Skin Rash	Yes	No
Boils/Abscess	Yes	No
Persistent Itch	Yes	No
Other	_____	

EYES

Blurred Vision	Yes	No
Double Vision	Yes	No
Pain	Yes	No
Other	_____	

MUSCULOSKELETAL

Joint Pain	Yes	No
Neck Pain	Yes	No
Back Pain	Yes	No
Other	_____	

ALLERGIES/IMMUNE SYSTEM

Hay Fever	Yes	No
Drug Allergies	Yes	No
Food Allergies	Yes	No
Other	_____	

EARS/NOSE/THROAT/MOUTH

Ear Infections	Yes	No
Sore Throats	Yes	No
Sinus Problems	Yes	No
Other	_____	

NEUROLOGICAL

Tremors	Yes	No
Dizzy Spells	Yes	No
Headache	Yes	No
Fainting	Yes	No
Other	_____	

GENITO/URINARY

Urinary Retention	Yes	No
Painful Urination	Yes	No
Urine Frequency	Yes	No
Other	_____	

GASTROINTESTINAL

Abdominal Pain	Yes	No
Nausea/Vomiting	Yes	No
Heartburn	Yes	No
Constipation	Yes	No
Diarrhea	Yes	No
Other	_____	

RESPIRATORY

Wheezing	Yes	No
Frequent Cough	Yes	No
Shortness of Breath	Yes	No
Other	_____	

CARDIOVASCULAR

Chest Pain	Yes	No
Chest Pressure	Yes	No
Palpitations	Yes	No
Other	_____	

BLOOD/LYMPH SYSTEM

Swollen Glands	Yes	No
Blood Clotting/ Bleeding Problems	Yes	No
Bruising	Yes	No
Other	_____	

Physician use only: (Comments/Notes)

Physician: _____ Date: _____