

# Texas Sports Medicine & Orthopaedic Group

## REVIEW OF SYSTEMS WORKSHEET

Name: \_\_\_\_\_ Date: \_\_\_\_\_

IN THE PAST MONTH, HAVE YOU EXPERIENCED ANY OF THE FOLLOWING? (Circle all that apply)

night sweats	change in sleeping habit	fainting
muscle weakness	numbness/tingling	cough
change in urination	bleeding	weight loss
weight gain	stiffness	fever
shortness of breath	chills	painful urination
nausea	shortness of breath	irregular heart beat
joint swelling	diarrhea	bruising
chest pain	wheezing	excessive thirst
vomiting	unusual stress	anxiety

NONE

PLEASE GIVE DETAILS OF ALL THAT YOU HAVE CIRCLED ABOVE:

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