Entira FAMILY CLINICS
Where generations thrive

DATE: _____ PATIENT NAME: _____ DATE OF BIRTH:_____

PRE-OPERATIVE - REVIEW OF SYSTEMS

(If you have any of the following symptoms, please check off)

Constitutional	☐	Fever, chills
EYE	☐ ☐	Eye pain Mattering
ENT	☐ ☐ ☐	Cold Cough Upper Respiratory Symptoms
Respiratory	☐ ☐ ☐	Chest Congestion Cough Wheezing
Cardiovascular	☐ ☐	Chest pain Palpitations (racing heart or skipped beats)
Gastroenterology	☐ ☐	Vomiting Diarrhea
Gynecology	☐	Currently pregnant

Musculoskeletal	☐ ☐	Leg Cramps Back Pain
Neurology	☐	Seizures
Dermatology	☐ ☐	Rash Hives
Hematology–Oncology	☐ ☐	Easy Bruising Swollen Glands
Urology	☐	Pain with Urination