McLaren Bariatric and Metabolic Institute
FLINT, MICHIGAN

REVIEW OF SYSTEMS

Patient Name _____ Date:____ /____ /_____
D.O.B: ____ /____ /_____ Age:_____
Referring Physician:_____ Gender (please circle): Male / Female

Maximum Weight: _____ **Maximum Weight Loss:** _____ **Minimum Adult Weight:** _____
Years Overweight: _____ **Years over 100lbs Overweight?**_____

Hospitalizations: _____
_____
_____

Past Surgeries: _____
_____
_____

PLEASE ANSWER THE FOLLOWING QUESTIONS

Do you have any problems with anesthesia? ☐ Yes ☐ No
If yes, what problem(s) did you experience?_____

Do you smoke or use tobacco? ☐ Yes ☐ No
If yes, how much?_____ How long? _____

Do you have a history of smoking? ☐ Yes ☐ No
If yes, how much? _____ How long did you smoke? _____ When did you quit? _____

Do you drink caffeinated beverages (e.g. coffee or cola)? ☐ Yes ☐ No
If yes, how much per day? _____What do you drink? _____

Do you use any recreational drugs (e.g. marijuana)? ☐ Yes ☐ No
If yes, what type? _____ How often? _____

Do you drink alcohol (e.g. beer, wine, liquor)? ☐ Yes ☐ No
If yes, what type? _____ How often (rare, social, daily)? _____

PHYSICAL ACTIVITY

Do you participate in any exercise? ☐ Yes ☐ No
If yes, what time?_____ How often? _____
How many minutes do you exercise at one time? _____
Describe any physical problems that prevent you from exercising: _____
_____
_____
_____
_____


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DR.

Allergies: _____

MEDICATIONS

Drug Name	Amount	How Often	Reason
Example – Advil	Two 400mg tablets	3 times a day	Joint Pain

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REVIEW OF SYSTEMS

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HISTORY & PHYSICAL EXAMINATION

PATIENT HISTORY: *(Please check and explain problem areas.)*

Review of System		Date Diagnosed/Comments
Constitutional		
Appetite decrease	☐ Yes ☐ No	
Chills	☐ Yes ☐ No	
Fever	☐ Yes ☐ No	
Night sweats	☐ Yes ☐ No	
Sleep problems	☐ Yes ☐ No	
Tiredness	☐ Yes ☐ No	
Unintentional weight loss	☐ Yes ☐ No	
Weight gain	☐ Yes ☐ No	
HEENT		
Difficulty with hearing	☐ Yes ☐ No	
Difficulty swallowing	☐ Yes ☐ No	
Dry eyes	☐ Yes ☐ No	
Eye or vision problems	☐ Yes ☐ No	
Hoarseness	☐ Yes ☐ No	
Recent nose bleed	☐ Yes ☐ No	
Ringing in ears	☐ Yes ☐ No	
Runny nose	☐ Yes ☐ No	
Sinus problems	☐ Yes ☐ No	
Stuffy nose	☐ Yes ☐ No	
Ringing in Ears	☐ Yes ☐ No	
Neck		
Neck lumps	☐ Yes ☐ No	
Neck pain	☐ Yes ☐ No	
Swelling of neck	☐ Yes ☐ No	
Respiratory		
Asthma	☐ Yes ☐ No	
Blood, Sputum	☐ Yes ☐ No	
Chronic cough	☐ Yes ☐ No	
Chronically tired	☐ Yes ☐ No	
Lung Disease	☐ Yes ☐ No	
Shortness of breath	☐ Yes ☐ No	
Sleep Apnea	☐ Yes ☐ No	
Snores heavily	☐ Yes ☐ No	
Wheezing	☐ Yes ☐ No	

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Cardiovascular

Arrhythmias	☐ Yes	☐ No	_____
Calf Tenderness	☐ Yes	☐ No	_____
Chest Pain, Angina	☐ Yes	☐ No	_____
Cramps in legs when walking	☐ Yes	☐ No	_____
Coronary or other heart disease	☐ Yes	☐ No	_____
Edema	☐ Yes	☐ No	_____
Heart Palpitations	☐ Yes	☐ No	_____
High Blood Pressure	☐ Yes	☐ No	_____
High Cholesterol	☐ Yes	☐ No	_____
High Triglycerides	☐ Yes	☐ No	_____
Stroke	☐ Yes	☐ No	_____

Skin

Change in pigmented lesion	☐ Yes	☐ No	_____
Itching	☐ Yes	☐ No	_____
Rash	☐ Yes	☐ No	_____
Yellowing of skin	☐ Yes	☐ No	_____

Gastrointestinal

Abdominal pain	☐ Yes	☐ No	_____
Black stools	☐ Yes	☐ No	_____
Blood in stool	☐ Yes	☐ No	_____
Bowel Disease	☐ Yes	☐ No	_____
Crohn's Disease	☐ Yes	☐ No	_____
Constipation	☐ Yes	☐ No	_____
Diarrhea	☐ Yes	☐ No	_____
Excess gas	☐ Yes	☐ No	_____
Gallbladder Disease	☐ Yes	☐ No	_____
Heartburn/GERD	☐ Yes	☐ No	_____
Hemorrhoids	☐ Yes	☐ No	_____
Hiatal Hernia	☐ Yes	☐ No	_____
HIV	☐ Yes	☐ No	_____
Liver Disease	☐ Yes	☐ No	_____
Nausea	☐ Yes	☐ No	_____
Regurgitating	☐ Yes	☐ No	_____
Ulcer	☐ Yes	☐ No	_____
Ulcerative Colitis	☐ Yes	☐ No	_____
Vomiting	☐ Yes	☐ No	_____

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Genito-Urinary

Blood in Urine	☐ Yes	☐ No	_____
Difficulty emptying	☐ Yes	☐ No	_____
Discharge	☐ Yes	☐ No	_____
Frequent Urination	☐ Yes	☐ No	_____
Kidney Disease	☐ Yes	☐ No	_____
Nephrotic Syndrome	☐ Yes	☐ No	_____
Pain with Urination	☐ Yes	☐ No	_____
Urinary incontinence	☐ Yes	☐ No	_____
Urinary Urgency	☐ Yes	☐ No	_____

Musculoskeletal

Ankle swelling	☐ Yes	☐ No	_____
Back pain	☐ Yes	☐ No	_____
Destructive joints	☐ Yes	☐ No	_____
Foot pain	☐ Yes	☐ No	_____
Joint pain	☐ Yes	☐ No	_____
Joint swelling	☐ Yes	☐ No	_____
Varicose veins	☐ Yes	☐ No	_____
Weakness arms or legs	☐ Yes	☐ No	_____

Neurological/Psychiatric/Emotional

Anorexia	☐ Yes	☐ No	_____
Bi-Polar Disorder	☐ Yes	☐ No	_____
Bulimia	☐ Yes	☐ No	_____
Depression	☐ Yes	☐ No	_____
Dizziness	☐ Yes	☐ No	_____
Fainting	☐ Yes	☐ No	_____
Headache	☐ Yes	☐ No	_____
Memory Loss	☐ Yes	☐ No	_____
Restless leg	☐ Yes	☐ No	_____
Seizure	☐ Yes	☐ No	_____
Substance abuse/addictions	☐ Yes	☐ No	_____
Suicide Attempt	☐ Yes	☐ No	_____
Tremors	☐ Yes	☐ No	_____

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Hematologic/Lymphatic/Immunologic

Abnormal bleeding	☐ Yes	☐ No_____
Blood Clots	☐ Yes	☐ No_____
If yes, do you have a filter in?	☐ Yes	☐ No_____
When was it put in?		_____
Is it still in?	☐ Yes	☐ No_____
If no, when was it removed?		_____
Bruise easily	☐ Yes	☐ No_____
Cancer	☐ Yes	☐ No_____
Lymphedema	☐ Yes	☐ No_____

Endocrine

Alopecia	☐ Yes	☐ No_____
Cold/heat intolerance	☐ Yes	☐ No_____
Diabetes	☐ Yes	☐ No_____
Excessive hair loss/growth	☐ Yes	☐ No_____
Excessive thirst	☐ Yes	☐ No_____
Excessive urination	☐ Yes	☐ No_____
Goiter	☐ Yes	☐ No_____
Hyperthyroid (high)	☐ Yes	☐ No_____
Hypothyroid (low)	☐ Yes	☐ No_____
Perimenopausal symptoms	☐ Yes	☐ No_____

☐ I have reviewed this with the patient and agree with above history and ROS.

Physician Signature: _____ Date: _____ / _____ / _____

Time: _____ : _____ a.m. / p.m.

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