J. KEVIN KAUFMAN, M.D., F.A.C.S.
Surgical Consultants of America
809 W. Harwood Rd Suite 202
Hurst, TX 76054
Phone: 817.377.0143
Fax: 817.377.0173

REVIEW OF SYSTEMS

NAME: _____ DOB: _____

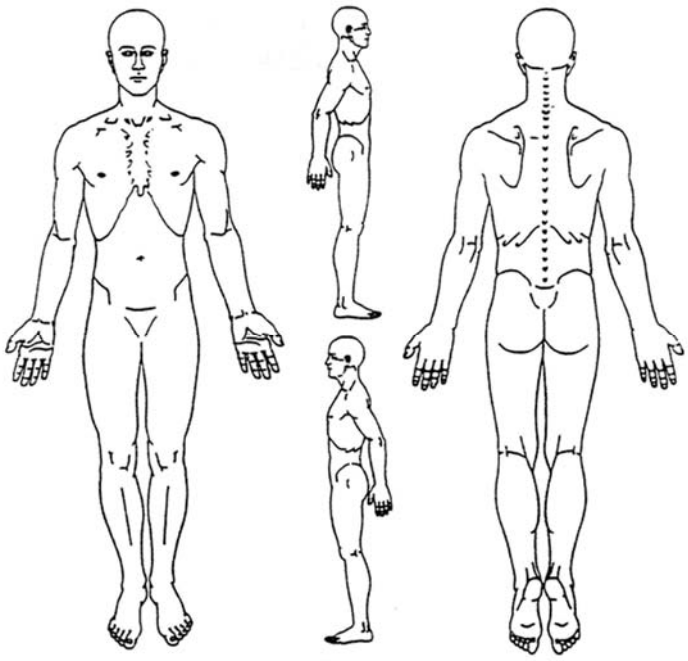
Do you currently have or have you had past problems with:					
CONSTITUTIONAL					
Excess Fatigue	YES	NO	Fever	YES	NO
Night Sweats	YES	NO	Weight Loss	YES	NO
EYES:					
Cataracts	YES	NO	Glaucoma	YES	NO
Infections	YES	NO	Wear Corrective Lenses	YES	NO
Injuries	YES	NO	Explain:		
Date of Last Exam:					
EAR, NOSE, THROAT & MOUTH:					
Balance Disturbance	YES	NO	Ear Infections	YES	NO
Hearing Loss	YES	NO	Ringing in Ears Right Left Both	YES	NO
Wearing Hearing Aids Last Exam: _____	YES	NO	Inability to Smell	YES	NO
Nasal Congestion	YES	NO	Nasal Drainage Color: _____	YES	NO
Nose Bleeds	YES	NO	Sinus Headaches	YES	NO
Sinus Problems	YES	NO	Mouth Sores	YES	NO
Sore Throats	YES	NO	Hoarseness	YES	NO
CARDIOVASCULAR:					
Chest Pain or Angina	YES	NO	Heart Murmur	YES	NO
High Blood Pressure	YES	NO	High Cholesterol	YES	NO
Irregular Pulse	YES	NO	Leg Pain While Walking	YES	NO
Swelling of Hands and/or Feet	YES	NO			
RESPIRATORY:					
Asthma	YES	NO	Bloody Sputum (Saliva)	YES	NO
Bronchitis	YES	NO	Chronic Cough	YES	NO
Emphysema	YES	NO	Lung Cancer	YES	NO
Pneumonia	YES	NO	Shortness of Breath	YES	NO
Date of Last Chest X-ray:					
GASTROINTESTINAL:					
Abdominal Pain	YES	NO	Blood in Vomit	YES	NO
Change in Bowel Habits	YES	NO	Colon Cancer	YES	NO
Indigestion or Pain with Eating	YES	NO	Jaundice	YES	NO
Liver Disease	YES	NO	Nausea	YES	NO

REVIEW OF SYSTEMS - CONTINUED

GENITOURINARY:					
Blood in Urine	YES	NO	Difficulty Staring or Stopping Urine Stream	YES	NO
Endometriosis (Female)	YES	NO	Incontinence	YES	NO
Kidney Stones	YES	NO	Painful Urination	YES	NO
Prostate Cancer (Male)	YES	NO	Urinary Tract Infections	YES	NO
Uterine or Cervical Cancer (Female)	YES	NO			
MUSCULOSKELETAL:					
Arm or Leg Numbness or Tingling	YES	NO	Arm or Leg Pain	YES	NO
Arm or Leg Weakness	YES	NO	Back Pain	YES	NO
Broken Bones	YES	NO	Joint Pain or Swelling	YES	NO
List:					
INTEGUMENTARY:					
Breast Pain, Tenderness, Swelling (Female)	YES	NO	Date Last Mammogram (Females)		
Nipple Discharge	YES	NO	Skin Cancer	YES	NO
Skin Disease	YES	NO			
NEUROLOGICAL:					
Difficulty with Speech	YES	NO	Difficulty with Coordination in Arms and/or Legs	YES	NO
Disorientation	YES	NO	Double o Blurred Vision	YES	NO
Face Weakness	YES	NO	Fainting Spells or "Blacking Out"	YES	NO
Headaches	YES	NO	Problems with Memory	YES	NO
Seizures	YES	NO			

Please place the appropriate letter in the areas of the body where you experience pain, burning, tingling and/or numbness on the drawings:

X - PAIN B - BURNING T - TINGLING W - WEAKNESS



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