

**University of Pittsburgh Physicians
Department of Neurological Surgery**

Patient Name: _____

Birth date: _____ Date: _____

Patient reported: Height: _____ ft _____ in Weight: _____ lbs

Review of Systems (please put x in all that apply)

I have no current symptoms: _____

	Y		Y		Y		Y
Fever		Shortness of Breath		Joint Pain		Seizures	
Weight Gain		Wheezing		Joint Swelling		Dizziness	
Weight Loss		Chronic Cough		Falls		Lightheadedness	
Malaise/Fatigue		Bloody Sputum		Leg/Arm Pain		Leg/Arm Weakness	
Night Sweats				Neck Pain		Numbness/Tingling	
Weakness		Chest Pain		Lower Back Pain		Speech Difficulty	
Decreased Appetite		Leg Cramping		Thoracic Pain		Disturbances in Coordination	
		Leg Swelling		Difficulty Walking			
Headaches				Muscle Cramps		Confusion	
Hearing Loss		Difficulty Swallowing				Disorientation	
Tinnitus		Nausea		Rash		Facial Spasm	
Throat Pain		Abdominal Pain		Skin Lesion		Facial Numbness	
Ear Pain		Blood in Stool		Mole Change		Facial Weakness	
Loose Teeth		Bowel Incontinence				Loss of Balance	
Facial Pain				Lumps in Neck		Loss of Smell	
		Bladder Incontinence		Lumps in Groin		Loss of Taste	
Blindness		Urgency		Easily Bruises/Bleeds			
Blurred Vision		Frequency				Depression	
Double Vision		Impotence		Frequent Infections		Nervous/Anxious	
Eye Pain		Pain when Urinating		Environmental Allergies		Memory Loss	
Loss of Vision		Urinary Burning					
				Cold Intolerance			
Nipple Discharge		Difficulty Urinating		Heat Intolerance			
		Loss of Menstrual Cycle		Excessive Thirst			

Other symptoms: _____
