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Review of Systems

Do you now or have you had any problems related to the following systems? Circle Yes or No. Please explain any yes answers in the space provided

Constitutional Symptoms

Fever Y N
Chills Y N
Headache Y N
Other Y N

Eyes

Blurred Vision Y N
Double Vision Y N
Pain Y N
Other Y N

Allergies

Hay Fever Y N
Drug Allergies Y N
Other Y N

Neurological

Tremor Y N
Dizzy Spells Y N
Numbness/Tingling Y N
Other Y N

Endocrine

Excessive Thirst Y N
Too hot/cold Y N
Tired/sluggish Y N
Other Y N

Gastrointestinal

Abdominal Pain Y N
Nausea/ Vomiting Y N
Indigestion/Heartburn Y N
Other Y N

Cardiovascular

Chest Pains Y N
Varicose Veins Y N
High Blood Pressure Y N
Other Y N

Integumentary

Skin Rash Y N
Boils Y N
Other Y N

Musculoskeletal

Joint Pain Y N
Neck Pain Y N
Back Pain Y N
Other Y N

Ear/Nose/Throat/Mouth

Ear Infection Y N
Sore Throat Y N
Sinus Problem Y N
Other Y N

Genitourinary

Urine Retention Y N
Painful Urination Y N
Urinary Retention Y N
Other Y N

Respiratory

Wheezing Y N
Frequent Cough Y N
Shortness of Breath Y N
Other Y N

Hematologic/ Lymphatic

Swollen Glands Y N
Blood Clotting Problem Y N
Other Y N

Psychological

Are you generally satisfied with your life? Y N
Do you feel severely depressed? Y N
Have you considered suicide? Y N
Other Y N

