CAPITAL SURGEONS GROUP, PLLC

REVIEW OF SYMPTOMS

NAME OF PATIENT: ____________________ DATE OF BIRTH: __________ DATE: __________

PLEASE CHECK THOSE WHICH ARE CHRONIC PROBLEMS:

GENERAL: YES

- HEADACHES ☐
- RADIATION EXPOSURE ☐
- VISION PROBLEMS ☐
- GLAUCOMA ☐
- HEARING PROBLEMS ☐
- LYMPH NODE SWELLING ☐
- THYROID PROBLEMS ☐
- ADRENAL PROBLEMS ☐
- WEIGHT LOSS OR GAIN ☐
- OTHER: __________

CARDIOVASCULAR:

- CHEST PAIN ☐
- SHORTNESS OF BREATH ☐
- SLEEP WITH MULTIPLE PILLOWS ☐
- WAKE UP WITH SHORTNESS OF BREATH ☐
- IRREGULAR HEART BEAT ☐
- RHEUMATIC FEVER ☐
- PHLEBITIS/DEEP VEIN THROMBOSIS ☐
- LEG OR FOOT PAIN AT NIGHT ☐
- HIGH CHOLESTEROL ☐
- LOW EXERCISE TOLERANCE ☐
  (i.e., Walk a Block With Shortness of Breath)
- OTHER: __________

URINARY AND PROSTATE:

- KIDNEY STONES ☐
- CHRONIC URINARY INFECTIONS ☐
- BLOOD IN URINE ☐
- PAINFUL URINATION ☐
- INCREASED FREQUENCY OF URINATION ☐
- URINATING MULTIPLE TIMES AT NIGHT ☐
- DECREASED FORCE OF STREAM ☐
- PROSTATE PROBLEMS ☐
- IMPOTENCE ☐
- OTHER: __________

OTHER:

- BLEEDING DISORDER ☐
- HISTORY OF ANEMIA ☐
- PREVIOUS BLOOD TRANSFUSIONS ☐
- TESTED POSITIVE FOR AIDS ☐
- TESTED POSITIVE FOR HEPATITIS - Type: ______ ☐
- OTHER: __________

GASTROINTESTINAL: YES

- NAUSEA ☐
- VOMITING ☐
- ABDOMINAL PAIN ☐
- JAUNDICE ☐
- GALLSTONES ☐
- HEART BURN / REFLUX ☐
- ULCERS ☐
- DIARRHEA ☐
- CONSTIPATION ☐
- BLACK TARRY STOOLS ☐
- BRIGHT RED BLOOD IN STOOLS ☐
- CHANGE IN STOOL
  (Color, Consistency or Frequency) ☐
- HEMORRHOIDS ☐
- OTHER: __________

NEUROLOGICAL:

- LEG OR ARM WEAKNESS ☐
- NUMBNESS ☐
- STROKE / TIA ☐
- PARALYSIS ☐
- BLACKOUTS ☐
- SEIZURES ☐
- OTHER: __________

LUNG:

- CHRONIC COUGH ☐
- SPUTUM PRODUCTION ☐
- BLOOD IN SPUTUM ☐
- PNEUMONIA ☐
- WHEEZING ☐
- ASTHMA ☐
- EMPHYSEMA ☐
- TUBERCULOSIS ☐
- OTHER: __________

PSYCHIATRIC:

- DEPRESSION ☐
- ANXIETY DISORDER ☐
- BIPOLAR DISORDER ☐
- EATING DISORDER ☐
- OTHER: __________ ☐

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SIGNATURE **DATE**