SURGICAL CARE P.C.

REVIEW OF SYSTEMS

DATE OF SERVICE: _____

GENERAL: Height _____ Weight _____ BMI _____

- ☐ Weight Change loss/gain
- ☐ Fatigue
- ☐ Weakness
- ☐ Fever
- ☐ Chills
- ☐ Night Sweats

Do you have a history of or are you currently experiencing any of the following?

CARDIORESPIRATORY:

- ☐ High blood pressure
- ☐ Heart attack
- ☐ Heart murmur/Rheumatic fever
- ☐ Mitral Valve Prolapse
- ☐ Chest pain
- ☐ Pacemaker/AICD
- ☐ Blood clot legs or lung
- ☐ Asthma/COPD
- ☐ Sleep Apnea/C-Pap
- ☐ Elevated Cholesterol
- ☐ Shortness of breath

GASTROINTESTINAL:

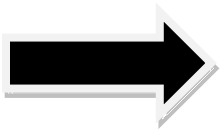
- ☐ Diarrhea
- ☐ Heartburn/Indigestion
- ☐ Hiatal Hernia
- ☐ Ulcers/Gastritis
- ☐ Nausea/vomiting
- ☐ Hepatitis
- ☐ Black or bloody stool
- ☐ Diverticulitis/Colitis/Crohn's
- ☐ Trouble Swallowing
- ☐ Hemorrhoids
- ☐ Liver disease/Cirrhosis
- ☐ Constipation
- ☐ Gallbladder Disease

MUSCULOSKELETAL:

- ☐ Arthritis
- ☐ Artificial Joints: _____
- ☐ Back/Neck pain
- ☐ Fibromyalgia
- ☐ Osteoarthritis
- ☐ Other Muscle/Bone problems _____

NEUROLOGICAL:

- ☐ Stroke
- ☐ Epilepsy/Seizures
- ☐ Headaches
- ☐ Depression
- ☐ Anxiety
- ☐ Parkinson's
- ☐ Multiple Sclerosis



ENDOCRINE:

- ☐ Anemia
- ☐ Thyroid Disease
- ☐ Diabetes
- ☐ Enlarged Lymph Nodes
- ☐ Blood Clotting Problems
- ☐ Easy Bruising
- ☐ Immune deficiency
- ☐ Other blood/lymph gland problems

GENITOURINARY:

- ☐ Kidney stones
- ☐ Kidney removed
- ☐ Blood in urine
- ☐ Enlarged Prostate
- ☐ Endometriosis
- ☐ Abnormal vaginal bleeding
- ☐ Other kidney/bladder problems

GYNECOLOGICAL:

Have you ever had breast cancer? ☐ Yes/☐ No

Have you ever had lobular or ductal carcinoma insitu? ☐ Yes/☐ No

Age of first menstrual period: _____

Age that your first child was born: _____

How many of your sisters, daughters or mother have had breast cancer? _____

Have you ever had a breast biopsy before? Yes/No If so, how many _____

Have prior breast biopsies showed atypical hyperplasia? Yes/No

Date of last menstrual period: _____

Total Number of Pregnancies: _____ Total Number carried to full term _____

Hormone replacement therapy (Include birth control pills, estrogen, progesterone, infertility Medications): _____

Did you breast feed? Yes/No _____

Age at menopause: _____

SKIN PROBLEMS:

- ☐ Psoriasis
- ☐ Melanoma
- ☐ Other skin cancers
- ☐ Previous biopsies
- ☐ Rashes
- ☐ Sores
- ☐ Lumps
- ☐ Leg Swelling

IMMUNIZATION:

If 65yrs or older, have you received a pneumonia vaccination? Y/ N Date:_____

If 50-70yrs of age, have you had a colonoscopy for colorectal cancer screening? Y/ N Date:_____

Patient Signature: _____ Date**:** _____

Transfusion Authorization

On an average, Surgical Care PC transfuses 5-6 patients annually, however medical emergencies occasionally warrant blood transfusion. The possible risks associated with transfusions include: Bruising, Fever, Immediate or delayed transfusion reaction and or transmission of infectious disease such as hepatitis or the AIDS virus.

The U.S. blood supply is among the safest in the world. The Public Health Service has recommended an approach to blood safety in the U.S. that includes stringent donor selection practices and the use of screening tests. The improvement of processing methods for blood products also has reduced the number of infections. Currently the risk of infection with HIV in the U.S. through receiving a blood transfusion or blood products is extremely low and has become progressively lower, even in geographic areas with high HIV prevalence rates.

If medically necessary, do you consent to a blood transfusion? This consent will be used only in the event of a medical emergency.
☐ No ☐ Yes

Patient Signature: _____ **Date:** _____ Revised 8/2016