

Surgical Associates of North Texas

Patient Name: _____ Date of Birth: _____

Location and Date of Recent Testing: _____

Reason for Today's Visit: _____

Is the condition due to a work related injury? () Yes () No If yes, please specify date of injury: _____

General Review of Systems – Check symptoms you currently have or have had in the past year

General:

- Chills
- Fatigue
- Fever
- Night Sweats
- Weight Gain > 10lbs.
- Weight Loss > 10lbs.

Skin:

- Bruising
- Rash
- Skin Color Changes

Respiratory:

- Chronic Cough
- Difficulty Breathing
- Tuberculosis

Cardiovascular:

- Chest Pain
- Difficulty Breathing On Exertion
- Irregular Heart Beat
- Elevated Blood Pressure
- Difficulty Breathing Lying Down
- Rapid Heart Rate
- Shortness of Breath
- Swelling of Extremities
- Pacemaker
- Vascular Disease

Gastrointestinal:

- Abdominal Pain
- Bloody Stool
- Change in Bowel Habits
- Constipation
- Diarrhea
- Nausea and Vomiting
- Hepatitis A, B, or C

Musculoskeletal:

- Muscle Pain
- Bone Pain
- Lymphedema

Female Genitourinary:

- Date of Last Menstrual Period: _____
- Are you currently pregnant? Yes No
- Are you currently breast-feeding? Yes No
- Complications with Urination
- Pelvic Pain
- Vaginal Bleeding
- Herpes
- Herpes
- Vaginal Infections

Male Genitourinary:

- Lump in Testicles
- Enlarged Scrotum
- Prostate Conditions
- Other: _____

Renal:

- Renal Insufficiency
- Renal Failure

Neurological:

- Blurred Vision
- Headaches
- Weakness In Extremities

Psychiatric:

- Anxiety
- Depression
- Insomnia
- Panic Attacks

Endocrine:

- Cold Intolerance
- Hair Changes
- Heat Intolerance

- Thyroid Problems

Hematology:

- Abnormal Bleeding
- Easy Bruising
- Enlarged Lymph Nodes
- Nose Bleed
- Prolonged Bleeding
- Anemia
- HIV or AIDS

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature: _____ Today's Date: _____