



Southern Surgical Associates, PA

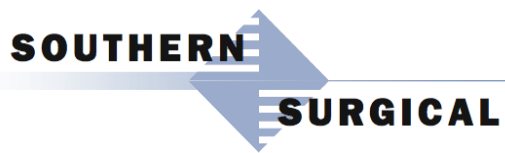
Wade Naziri, MD William Chapman, MD Julie Johannes, PA-C

REVIEW OF SYSTEMS: (Tell us what you are currently experiencing or feeling)

<p>Y N</p> <p style="text-align: center;"><u>GENERAL</u></p> <p><input type="checkbox"/> <input type="checkbox"/> Weight Loss</p> <p><input type="checkbox"/> <input type="checkbox"/> Weight Gain</p> <p><input type="checkbox"/> <input type="checkbox"/> Fever</p> <p><input type="checkbox"/> <input type="checkbox"/> Night Sweats</p> <p><input type="checkbox"/> <input type="checkbox"/> Fatigue</p> <p style="text-align: center;"><u>EYES</u></p> <p><input type="checkbox"/> <input type="checkbox"/> Blurred Vision</p> <p><input type="checkbox"/> <input type="checkbox"/> Double Vision</p> <p><input type="checkbox"/> <input type="checkbox"/> Corrective Lenses</p> <p><input type="checkbox"/> <input type="checkbox"/> Glaucoma</p> <p><input type="checkbox"/> <input type="checkbox"/> Cataracts</p> <p style="text-align: center;"><u>EARS/NOSE/MOUTH/THROAT</u></p> <p><input type="checkbox"/> <input type="checkbox"/> Ringing in Ears</p> <p><input type="checkbox"/> <input type="checkbox"/> Sinus Trouble</p> <p><input type="checkbox"/> <input type="checkbox"/> Swollen Glands in Neck</p> <p><input type="checkbox"/> <input type="checkbox"/> Hearing Loss</p> <p><input type="checkbox"/> <input type="checkbox"/> Bleeding Gums</p> <p><input type="checkbox"/> <input type="checkbox"/> Nose Bleeds</p> <p style="text-align: center;"><u>CARDIOVASCULAR</u></p> <p><input type="checkbox"/> <input type="checkbox"/> Chest Pain</p> <p><input type="checkbox"/> <input type="checkbox"/> Heart fluttering/racing</p> <p><input type="checkbox"/> <input type="checkbox"/> Heart Murmur</p> <p><input type="checkbox"/> <input type="checkbox"/> Leg Swelling</p> <p><input type="checkbox"/> <input type="checkbox"/> Venous Insufficiency</p>	<p>Y N</p> <p style="text-align: center;"><u>RESPIRATORY</u></p> <p><input type="checkbox"/> <input type="checkbox"/> Shortness of Breath</p> <p><input type="checkbox"/> <input type="checkbox"/> Wheezing</p> <p><input type="checkbox"/> <input type="checkbox"/> Persistent Cough</p> <p><input type="checkbox"/> <input type="checkbox"/> Spitting up Blood</p> <p><input type="checkbox"/> <input type="checkbox"/> Pneumonia</p> <p style="text-align: center;"><u>GASTROINTESTINAL</u></p> <p><input type="checkbox"/> <input type="checkbox"/> Nausea</p> <p><input type="checkbox"/> <input type="checkbox"/> Vomiting</p> <p><input type="checkbox"/> <input type="checkbox"/> Constipation</p> <p><input type="checkbox"/> <input type="checkbox"/> Diarrhea</p> <p><input type="checkbox"/> <input type="checkbox"/> Rectal Bleeding</p> <p><input type="checkbox"/> <input type="checkbox"/> Black Stools</p> <p><input type="checkbox"/> <input type="checkbox"/> Trouble Swallowing</p> <p><input type="checkbox"/> <input type="checkbox"/> Heartburn</p> <p><input type="checkbox"/> <input type="checkbox"/> Loss of Appetite</p> <p style="text-align: center;"><u>HEMATOLOGIC/LYMPHATIC</u></p> <p><input type="checkbox"/> <input type="checkbox"/> Easy Bruising</p> <p><input type="checkbox"/> <input type="checkbox"/> Enlarged Glands</p> <p style="text-align: center;"><u>ENDOCRINE/RENAL</u></p> <p><input type="checkbox"/> <input type="checkbox"/> Thyroid Problems</p> <p><input type="checkbox"/> <input type="checkbox"/> Excessive Thirst or Urination</p> <p><input type="checkbox"/> <input type="checkbox"/> Hormone Problem</p> <p><input type="checkbox"/> <input type="checkbox"/> Heat/Cold Intolerance</p> <p style="text-align: center;"><u>MUSCULAR/SKELETAL</u></p> <p><input type="checkbox"/> <input type="checkbox"/> Back Pain</p>	<p>Y N</p> <p><input type="checkbox"/> <input type="checkbox"/> Muscle Cramping</p> <p><input type="checkbox"/> <input type="checkbox"/> Cold Extremities</p> <p><input type="checkbox"/> <input type="checkbox"/> Joint Pain</p> <p><input type="checkbox"/> <input type="checkbox"/> Pain in Legs with Walking</p> <p style="text-align: center;"><u>NEUROLOGICAL</u></p> <p><input type="checkbox"/> <input type="checkbox"/> Seizures</p> <p><input type="checkbox"/> <input type="checkbox"/> Stroke</p> <p><input type="checkbox"/> <input type="checkbox"/> Numbness/tingling</p> <p><input type="checkbox"/> <input type="checkbox"/> Headache</p> <p style="text-align: center;"><u>INTEGUMENTARY</u></p> <p><input type="checkbox"/> <input type="checkbox"/> Rash</p> <p><input type="checkbox"/> <input type="checkbox"/> Lesions</p> <p><input type="checkbox"/> <input type="checkbox"/> Itching</p> <p style="text-align: center;"><u>GENITOURINARY</u></p> <p><input type="checkbox"/> <input type="checkbox"/> Pain with Urination</p> <p><input type="checkbox"/> <input type="checkbox"/> Blood in Urine</p> <p><input type="checkbox"/> <input type="checkbox"/> Frequent Urination</p> <p><input type="checkbox"/> <input type="checkbox"/> Difficult Catheterization</p> <p><input type="checkbox"/> <input type="checkbox"/> Urinary Tract Infection</p> <p style="text-align: center;"><u>ALLERGY/IMMUNOLOGIC</u></p> <p><input type="checkbox"/> <input type="checkbox"/> Seasonal Allergies</p> <p><input type="checkbox"/> <input type="checkbox"/> Frequent or Unusual Infections</p>
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FAMILY HISTORY:

	Living	Deceased	Age	Health Problems/Cause of Death
Father				
Mother				
Brothers				
Sisters				



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SURGICAL/PROCEDURE HISTORY:

	When		When
Appendectomy		Hemorrhoidectomy	
Back Surgery		Hernia Repair	
C-Section		Hip Replacement	
Cardiac Bypass		Hysterectomy	
Cardiac Cath		Knee Replacement	
Carpal Tunnel		Lap or Open Gallbladder	
Cataract		Mastectomy	
Colon Resection		Nissen (reflux surgery)	
Defibrillator		Pace Maker	
Endoscopy		Tonsillectomy	
Gastric Band		Tubal Ligation	
Gastric Sleeve		Other _____	
Gastric Bypass		Other _____	

SOCIAL HISTORY:

Tobacco Use: Never Previously but quit Daily *Amount:* _____ *Type:* Cigarettes Chew Snuff
 Alcohol Use: Never Rare Moderate Frequent
 Street Drug Use: No Yes *Type/Frequency:* _____
 Marital Status: Single Married Divorced Separated Widowed
 Occupation: _____ Full Time Part Time

ALLERGIES:

None

Name of Medication	Type of Reaction

MEDICATIONS:

Medication	Dose/Strength	How Often?

I declare that the above information is accurate to the best of my knowledge.

Signature

Date