PULASKI SURGERY CLINIC

PATIENT SIGNS AND SYMPTOMS

Please give the most recent date and location of the following:

Stomach Scope (EGD) __________________ Date ____________

Colonscopy ________ Date _____________

Mammogram ________________________ Date ____________

TB Skin Test ________ Date _____________

CT/Ultrasound/Diagnostic xrays____

Please check if you are currently having any of the following signs or symptoms:

General:

___Weight Loss ____lbs.

___Weight Gain ____lbs.

___ Fever

___Fatigue

___Night Sweats

Skin:

___ Rash

___Sores

___ Itching

___Change in hair/ nails

Head/Ears/Eyes/Nose/Throat:

___ History of head or neck trauma

___Sore Throat

___ Hoarseness

___Sinus Problems

___ Earaches

Breast:

___ History of breast lumps or masses

___ Fibrocystic breast disease

___ Nipple Discharge

___ Nipple Inversion

___ Pain in breast

Respiratory:

___ Cough

___ Shortness of Breath

___ Wheezing

___ History of TB

___ Sleep Apnea

Cardiovascular:

___ Heart palpitations/irregular heart beat

___ Chest pain

___ Heart murmur

___ Swelling in feet

Last cardiac evaluation_____________

Gastrointestinal:

___ Abdominal pain

___ Nausea

___Vomiting

___ Diarrhea

___Constipation

___ Bloody Stools

___ Dark/black stools

___Difficulty swallowing

___ Hemorrhoids

Genitourinary:

___ Difficulty urinating

___ Pain with urinations

___Inability to hold urine

___Blood in urine

___Urinary frequency

How many pregnancies? _______

How many children? ______

Any miscarriages? ______

Last pap smear/Dr. _______________________

Last prostate exam/Dr. ____________________

Musculoskeletal:

___ Rheumatoid arthritis

___ Osteoarthritis

___ Joint pain

___Use cane /__ walker/ __ wheelchair

___ Pain in legs with walking_____ blocks

Neurological:

___ Tremors

___ Headache/ ___ Migraines

___ Seizures Last one? __________

___Dizziness

Patient Signature____

Date____

Rev 11/25/13