

**Watauga Surgical Group, P.A.**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

Primary Care Physician \_\_\_\_\_

Referring Physician \_\_\_\_\_

Have you recently had the following: Circle Yes or No; if in doubt, leave blank.

**REVIEW OF SYSTEMS**

**GENERAL**

Weakness	Yes	No
Marked Weight Gain or Weight Loss	Yes	No
Night Sweats	Yes	No
Persistent Fever	Yes	No

**SKIN**

Rashes	Yes	No
Jaundice	Yes	No

**EYES**

Vision Changes	Yes	No
Double Vision	Yes	No

**EARS, NOSE, THROAT**

Hoarseness	Yes	No
Post Nasal Drip	Yes	No

**RESPIRATORY**

Bloody Sputum	Yes	No
Cough, Persisting	Yes	No
Difficulty Breathing while Lying Down	Yes	No
Shortness of Breath	Yes	No
Sputum (Phlegm)	Yes	No
Wheezing	Yes	No

**CARDIOVASCULAR**

Chest Pain	Yes	No
Palpitations	Yes	No

**GENITOURINARY**

Blood in Urine	Yes	No
Painful Urination	Yes	No

**TUBERCULOSIS**

Have you ever had Tuberculosis Yes No

If yes, were you treated \_\_\_\_\_

Have you ever had a positive PPD Test Yes No

If yes, were you treated \_\_\_\_\_

Have you ever been diagnosed with an infectious disease? Yes No

If yes, what disease? \_\_\_\_\_

**DIGESTIVE SYSTEM**

Change in Appetite	Yes	No
Difficulty Swallowing	Yes	No
Heartburn	Yes	No
Abdominal Pain	Yes	No
Nausea	Yes	No
Vomiting	Yes	No
Vomiting of Blood	Yes	No
Rectal Bleeding	Yes	No
Tarry Stools	Yes	No
Constipation	Yes	No
Diarrhea	Yes	No
Hemorrhoids	Yes	No
Bloating	Yes	No
Change in Bowel Habits	Yes	No

**MUSCULOSKELETAL**

Muscle Weakness	Yes	No
Calf pain when walking	Yes	No
Back Pain	Yes	No

**HEMATOLOGY**

Excessive Bleeding	Yes	No
Easy Bruising	Yes	No

**NERVOUS SYSTEM**

Headaches	Yes	No
Fainting	Yes	No
Weakness or Paralysis	Yes	No

\_\_\_\_\_  
Patient Signature Date

\_\_\_\_\_  
Physician Signature Date

**COMPLETE REVERSE SIDE**

