Alessi Vascular Surgery, PC

Patient Name:_____ Date:_____

REVIEW OF SYSTEMS

Check if you currently have any of the following problems:

CONSTITUTIONAL

___Chills

___Fatigue

___Fever

___Weight loss/Gain

___Other_____

HEENT

___Dental Problems

___Hearing Loss

___Nasal drainage/Sinus

___Burred/Double vision

___Glaucoma

___Other_____

RESPIRATORY

___Chronic cough

___Shortness of Breath

___Wheezing

___Asthma

___Other_____

HEMATOLOGIC/ LYMPH

___Easy bleeding

___Easy bruising

___Other_____

CARDIOVASCULAR

___Artificial heart valves

___Chest pains

___History of blood transfer

___Irregular/rapid heartbeat

___Poor circulation

___Swelling of ankles or feet

___Varicose veins

___Other_____

Date of last EKG:_____

GASTROINTESTIONAL

___Incontinence

___Change in stool

___Constipation

___Nausea

___Vomiting

___Other_____

GENITOURINARY

___Urinary frequency

___Urinary incontinence

___Urinary retention

___Painful urination

___Other_____

IMMUNOLOGIC

___Seasonal allergies

___Food allergies

___Other_____

REPRODUCTIVE

___Vaginal discharge

___Irregular menses

___Erectile dysfunction

___Penile discharge

___Other_____

INTEGUMENTARY

___Redness

___Rash

___Hives

___Skin lesion

___Hair loss

___Other_____

___Seizures

___Other_____

PSYCHIATRIC

___Anxiety

___Depression

___Insomnia

___Paranoia

___Other_____

NEUROLOGICAL

___Dizziness

___Numbness

___Weakness

___Tingling

___Gait disturbance

___Headache

___Memory loss/confusion

___Tremor

___Seizures

___Other_____

METABOLIC/ENDO

___Nipple discharge

___Heat/Cold intolerance

___Diabetes

___Excessive thirst

___Excessive hunger

___Other_____

MUSCULOSKELETAL

___Back pain

___Neck pain

___Joint pain

___Joint swelling

___Muscle weakness

___Other_____

The above information is accurate to the best of my knowledge.

_____ _____

Patient/Guardian Signature Date