In the last year have you had any of the following symptoms? **Surgical Services, PC**

Constitutional:

Chills	No	Yes
Fatigue	No	Yes
Fever	No	Yes
Night sweats	No	Yes
Weight gain	No	Yes
Weight loss	No	Yes

Others___________________________________

HEENT:

Eye pain	No	Yes
Hearing loss	No	Yes
Nasal drainage	No	Yes
Sinus pressure	No	Yes
Sore throat	No	Yes
Visual changes	No	Yes

Others ___________________________________

Respiratory:

Cough	No	Yes
Known TB exposure	No	Yes
Shortness of breath	No	Yes
Wheezing	No	Yes

Others ___________________________________

Cardiovascular:

Chest pain/pressure	No	Yes
Edema	No	Yes
Rapid heart rate	No	Yes

Others___________________________________

Gastrointestinal:

Abdominal pain	No	Yes
Blood in stools	No	Yes
Change in stools	No	Yes
Constipation	No	Yes
Diarrhea	No	Yes
Heartburn/indigestion	No	Yes
Loss of appetite	No	Yes
Nausea	No	Yes
Vomiting	No	Yes

Others___________________________________

Integumentary:

Mole changes	No	Yes
Rash	No	Yes
Skin lesion	No	Yes

Others ___________________________________

Musculoskeletal:

Back Pain	No	Yes
Joint pain	No	Yes
Joint swelling	No	Yes
Muscle weakness	No	Yes
Neck pain	No	Yes

Others ___________________________________

Genitourinary:

Pain with urinating	No	Yes
Blood in urine	No	Yes
Urinary frequency	No	Yes
Urinary incontinence	No	Yes
Urinary retention	No	Yes

Others ___________________________

Reproductive:

Breast discharge	No	Yes
Breast lump	No	Yes
Hot flashes	No	Yes
Irregular menses	No	Yes
Vaginal discharge	No	Yes

Others___________________________

Metabolic/Endocrine:

Cold intolerance	No	Yes
Heat intolerance	No	Yes
Hirsutism	No	Yes
Extreme thirst	No	Yes
Extreme hunger	No	Yes

Others ___________________________

Neurological:

Dizziness	No	Yes
Extremity numbness	No	Yes
Extremity weakness	No	Yes
Gait disturbance	No	Yes
Headaches	No	Yes
Memory loss	No	Yes
Seizures	No	Yes

Others___________________________

Psychiatric:

Anxiety	No	Yes
Depression	No	Yes
Insomnia	No	Yes

Others ___________________________

Hematologic/Lymphatic

Easy bleeding	No	Yes
Easy bruising	No	Yes
Lymph node swelling	No	Yes

Others ___________________________

Immunologic

Environmental allergies	No	Yes
Food allergies	No	Yes
Seasonal allergies	No	Yes

Others ___________________________

I certify to the best of my knowledge that the above information is correct.

Signed ______________________________Date __________
Patient / Representative