SURGICAL ASSOCIATES OF NEW HAVEN, P.C.
SYSTEMS REVIEW

Name: _____Date of Birth:_____

Please read carefully over the following lists of problems and circle, any which apply, to you. If none apply, circle "none". Give further details, if appropriate, at bottom. Please sign at the bottom.

1. General:

Fever	Weight loss	None
Night sweats	Decreased energy	

2. Eyes:

Change in vision	Pain	None
Glaucoma	Infection	

3. Mouth, Ears, Nose and Throat:

Ear pain	Nose bleed	None
Hoarseness	Deafness	
Sinus problem	Bleeding gums	

4. Cardiovascular:

Chest pain	High blood pressure	None
Palpitations	Shortness of breath with/without exertion	
Shortness of breath at night	Varicose veins	
Leg swelling		

5. Respiratory:

Cough	Sputum	None
Bloody sputum	Wheezing	
Asthma	Emphysema	

Date of last chest X-ray:_____

6. Digestion:

Change in appetite	Gas	None
Abdominal pain	Nausea	
Food intolerance	Jaundice	
Vomiting	Vomiting blood	
Hemorrhoids	Hernia	
Trouble swallowing	Heartburn	
Bloody stool	Tarry stool	
Change in bowel habits	Diarrhea	
Constipation		

Please Turn Over

7. Urinary/Genital:

Blood in urine	Increased frequency of urination	None
Pain on urination	Trouble urinating	
Infections of bladder/kidneys	Incontinence	
Sexually transmitted diseases	Pain in testes	
Swelling of testes		

8. Musculoskeletal:

Bone pain	Joint pain	None
Arthritis		

9. Skin:

Color change	Bleeding	None
Infection	Change in mole	
Bruising		

10. Breasts:

Lumps	Pain	None
Nipple discharge		

11. Neurologic:

Headache	Seizures	None
Weakness	Dizziness	
Paralysis	Trouble walking/talking	

12. Psychiatric:

Depression	Insomnia	None
Memory loss	Anxiety	

13. Endocrine:

Diabetes	Thyroid problems	None
Goiter		

14. Blood/Lymphatic:

Anemia	Enlarged lymph nodes	None
Infectious problems	HIV positive	
Bleeding problems	Clotting problems	

DETAILS OF ABOVE:

Patient Signature:_____

Physician Signature: _____

Date:_____