

VASCULAR SURGERY REVIEW OF SYSTEMS

Today's Date: _____

Patient Name: _____

Date of Birth: _____

What is the reason for your visit today, and how long have you had this problem? _____

Please check if you are experiencing or have experienced the following symptoms.

Review of Symptoms

General	<input type="checkbox"/> Weakness	Endocrine	<input type="checkbox"/> Heat intolerance
	<input type="checkbox"/> Lack of appetite		<input type="checkbox"/> Cold intolerance
	<input type="checkbox"/> Weight Loss		<input type="checkbox"/> Increased thirst
Eyes	<input type="checkbox"/> Decreased ability to see	Musculoskeletal	<input type="checkbox"/> Neck Pain
	<input type="checkbox"/> Loss of vision	(Bone, joint or muscle problems)	<input type="checkbox"/> Back pain
Skin	<input type="checkbox"/> Change in skin color or temperature		<input type="checkbox"/> Right arm pain
	<input type="checkbox"/> Hair growth change, ulcers	pain	<input type="checkbox"/> Left arm
	<input type="checkbox"/> Nail changes		<input type="checkbox"/> Pain down your legs
	<input type="checkbox"/> Skin ulcers		<input type="checkbox"/> Right leg pain
Respiratory (Lung or breathing problems)	<input type="checkbox"/> Asthma		<input type="checkbox"/> Left leg pain
	<input type="checkbox"/> Shortness of breath at rest		<input type="checkbox"/> Painful joints
	<input type="checkbox"/> Shortness of breath with exertion		<input type="checkbox"/> Deformities of the joints or extremities
Cardiovascular (Heart problems)	<input type="checkbox"/> Chest pain/tightness/squeezing, irregular heartbeat	Neurologic (Brain or nerve problems)	<input type="checkbox"/> Weakness, headaches, pre-syncope, syncope
	<input type="checkbox"/> Need to sit up to breathe		<input type="checkbox"/> Blackouts
	<input type="checkbox"/> Irregular heart beat (palpitations)		<input type="checkbox"/> Dizziness
	<input type="checkbox"/> Swelling of the legs		<input type="checkbox"/> Double vision
	<input type="checkbox"/> Varicose Veins		<input type="checkbox"/> Numbness or tingling of the extremities
	<input type="checkbox"/> Heaviness		<input type="checkbox"/> Paralysis or weakness of limbs
	<input type="checkbox"/> Achiness		<input type="checkbox"/> Loss of sensation
	<input type="checkbox"/> Fatigue		<input type="checkbox"/> Loss of balance or coordination
	<input type="checkbox"/> Leg pain at rest		<input type="checkbox"/> Problems speaking
	<input type="checkbox"/> Leg pain with exertion	Psychiatric (Mental health)	<input type="checkbox"/> Depression
	<input type="checkbox"/> Blue/purple discoloration of hands/feet		<input type="checkbox"/> Anxiety
Gastrointestinal (GI or abdominal problems)	<input type="checkbox"/> Nausea	Contact Precaution	<input type="checkbox"/> HIV
	<input type="checkbox"/> Vomiting		<input type="checkbox"/> Hepatitis C
	<input type="checkbox"/> Diarrhea		<input type="checkbox"/> MRSA
	<input type="checkbox"/> Abdominal pain		<input type="checkbox"/> C-DIFF
	<input type="checkbox"/> Abdominal pain after eating		<input type="checkbox"/> Norovirus
	<input type="checkbox"/> Blood in stools		<input type="checkbox"/> TB
Genito-urinary System (Urination problems)	<input type="checkbox"/> Pain or burning on urination		<input type="checkbox"/> Measles
	<input type="checkbox"/> Frequent urination		<input type="checkbox"/> Chicken pox
	<input type="checkbox"/> Unusually large volumes of urine		<input type="checkbox"/> Staphylococcus Aureus
	<input type="checkbox"/> Extreme urge to urinate		

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