MID-SOUTH SURGEONS, PLLC

Patient Name: _____ **Please fill the bubble in for all that apply**

Smoking: O Yes O No O Second Hand Smoke O 1 ppd O 2 ppd O 3+ ppd O > 5yrs
O 6-15 yrs O 16-20 yrs O 20+ yrs

Alcohol Use: O Yes O No O daily O weekly O monthly O socially

Recreational/Illicit Drugs: O Yes O No O Marijuana O Heroin O Cocaine O Other _____

Colon Cancer Screening/Colonoscopy in the past 10 years: O Yes O No

Mammogram in the past 2 years: O Yes O No

Review of Systems: *Are you currently experiencing any of the following?*

Fever	O	Yes	O	No	Frequent Urination	O	Yes	O	No
Fatigue	O	Yes	O	No	Blood in urine	O	Yes	O	No
Weight change	O	Yes	O	No	Hypothyroidism	O	Yes	O	No
Loss of vision	O	Yes	O	No	Depression	O	Yes	O	No
Eye irritation	O	Yes	O	No	Anxiety	O	Yes	O	No
Blurring of vision	O	Yes	O	No	Rash	O	Yes	O	No
Ear aches	O	Yes	O	No	Skin cancer	O	Yes	O	No
Runny nose/scratchy throat	O	Yes	O	No	Nasal congestion	O	Yes	O	No
Chest congestion	O	Yes	O	No	Allergies	O	Yes	O	No
Cough	O	Yes	O	No	Weakness, numbness, paralysis	O	Yes	O	No
Chest pain	O	Yes	O	No	Tingling, numbness	O	Yes	O	No
Palpitations	O	Yes	O	No	History of anemia	O	Yes	O	No
Irregular pulse or heart beat	O	Yes	O	No	Hemorrhage	O	Yes	O	No
Shortness of breath	O	Yes	O	No	Blood transfusion	O	Yes	O	No
Edema	O	Yes	O	No	Muscle aches	O	Yes	O	No
Diarrhea	O	Yes	O	No	Back pain	O	Yes	O	No
Difficulty swallowing	O	Yes	O	No	Leg pain with walking	O	Yes	O	No
Heartburn	O	Yes	O	No	Sensation changes in legs or arms	O	Yes	O	No
Nausea	O	Yes	O	No	Toes turning blue and painful	O	Yes	O	No
Abdominal pain	O	Yes	O	No	Foot or leg ulcers	O	Yes	O	No
Blood in stool	O	Yes	O	No					
Voiding dysfunction	O	Yes	O	No					