



# SURGICAL SPECIALISTS QUESTIONNAIRE

Today's Date \_\_\_\_\_ First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ Language \_\_\_\_\_ Height (feet/inches) \_\_\_\_\_ Weight (pounds) \_\_\_\_\_

Reason for today's appointment (symptoms, onset, duration): \_\_\_\_\_

Recent tests or x-rays (when and where): \_\_\_\_\_

Do you have an advanced directive?  Yes  No If yes, who is your surrogate decision maker? \_\_\_\_\_

Joint replacement in last 6 months?  Yes  No Date of last influenza vaccination \_\_\_\_\_

If you are 50 years old or older, date of your last colonoscopy \_\_\_\_\_

Current smoker -- How much/how long? \_\_\_\_\_  Chewing tobacco  Former smoker -- Date quit \_\_\_\_\_  Never smoked

**REVIEW OF SYSTEMS:** Please check any new symptoms you have experienced in the last MONTH.

**Constitutional/General**

- Yes  No Fever
- Yes  No Chills
- Yes  No Heavy Sweating/Night Sweats
- Yes  No Loss of Appetite
- Yes  No Sleep Disturbances
- Yes  No Unexplained Weight Loss/Gain
- Other: \_\_\_\_\_

**Eyes**

- Yes  No Blurry Vision
- Yes  No Double Vision
- Yes  No Wear Glasses
- Other: \_\_\_\_\_

**Ear/Nose/Throat**

- Yes  No Sore Throat
- Yes  No Mouth Sores
- Yes  No Nasal Congestion/Sinus Issues
- Yes  No Hearing Loss
- Other: \_\_\_\_\_

**Respiratory**

- Yes  No Cough
- Yes  No COPD
- Yes  No Wheezing
- Yes  No Recurrent Respiratory Infections
- Yes  No Shortness of Breath
- Other: \_\_\_\_\_

**Endocrine**

- Yes  No Excessive Thirst/Fluid Intake
- Yes  No Temperature Intolerance
- Yes  No Feeling Tired (Fatigue)
- Yes  No Hot Flashes
- Other: \_\_\_\_\_

**Genitourinary**

- Yes  No Painful urination
- Yes  No Urinary Frequency
- Yes  No Loss of Urinary Control
- Yes  No Enlarged Prostate
- Yes  No Difficulty Urinating
- Other: \_\_\_\_\_

**Skin**

- Yes  No Skin Rash
- Yes  No Itching
- Yes  No Discoloration
- Yes  No Lumps or Masses
- Other: \_\_\_\_\_

**Musculoskeletal**

- Yes  No Joint Pain
- Yes  No Joint Swelling
- Yes  No Back Pain
- Yes  No Limitation of Motion
- Yes  No Neck Pain
- Yes  No Pain with Walking
- Other: \_\_\_\_\_

**Cardiovascular**

- Yes  No Chest Pain or Discomfort
- Yes  No Swelling Feet, Ankles, Legs
- Yes  No Irregular Heartbeat
- Yes  No Heart Attack
- Yes  No Palpitations
- Yes  No Varicose Veins
- Other: \_\_\_\_\_

**Pain**

Current pain rating (0-10) \_\_\_\_\_  
Location \_\_\_\_\_

**Hematologic/Lymphatic**

- Yes  No Swollen Glands
- Yes  No Blood Clotting Problem
- Yes  No Easy Bruising
- Yes  No Bleeding Tendencies
- Other: \_\_\_\_\_

**Neurological**

- Yes  No Tremors
- Yes  No Dizzy Spells
- Yes  No Numbness/Tingling
- Yes  No Headache
- Yes  No Unsteady Gait
- Yes  No Feeling Weak
- Yes  No Convulsions/Seizures
- Other: \_\_\_\_\_

**Gastrointestinal**

- Yes  No Abdominal Pain
- Yes  No Nausea/Vomiting
- Yes  No Indigestion/Heartburn
- Yes  No Blood in Stools
- Yes  No Change in Bowel Habits
- Yes  No Rectal Bleeding
- Yes  No Diarrhea
- Yes  No Constipation
- Yes  No Swallowing Difficulties
- Other: \_\_\_\_\_

**Female Patients Only**

Age of first menstrual period \_\_\_\_\_  
Last menstrual period \_\_\_\_\_  
Number of pregnancies \_\_\_\_\_  
Number of life births \_\_\_\_\_  
Age menopause occurred \_\_\_\_\_  
 Yes  No Breast Pain  
 Yes  No Breast Lump/Mass  
 Yes  No Change in Nipple

*This form is destroyed after the information is entered and verified in the patient's electronic health record.*