Your Northland Vein Center
Fall General Surgery, LLC

Review of Systems

What would you like to discuss at your visit today? ______________________________

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Do you *currently* have any of the following:	No	Yes	If Yes, Please explain:
Arthritis/Joint Pain			
Back Pain or Injury			
Chest Pain			
Abdominal Pain			
Heartburn/Reflux			
Belching/Bloating			
Stool Changes			
Hemorrhoids			
Urinary Changes			
Fever/Chills			
Nausea/Vomiting			
Fatigue			
Weight Changes			
Night Sweats			
Dizziness/Fainting			
Headaches/Migraines			
Hearing Loss			
Hernia			
Cough			
Shortness of Breath			
Memory Problems			
Leg Pain/Heaviness			
Numbness/Weakness			
Rash/Open wounds			
Swelling			
Vision/Eye Problems			
Tobacco Use			
Alcohol Use			
Drug/Marijuana Use			

Patient Signature: ______________________________ **Date:** ____________________

Printed Name: ______________________________ **DOB:** ____________________