

REVIEW OF SYSTEMS

NEW PATIENT

RETURN VISIT

DATE _____

PATIENT'S NAME _____

TODAY'S MAIN COMPLAINT _____

FOR RETURN VISITS, LIST NEW/CHANGED MEDICATION _____

FOR RETURN VISITS, HAVE YOU HAVE ANY NEW SYMPTOMS SINCE YOUR LAST VISIT? _____

IF YES, SPECIFY _____

PLEASE CHECK ONLY THOSE THAT APPLY

GENERAL

- Weight loss? How much? _____
- Decrease in energy
- Decrease in appetite
- Night sweats
- Difficulty sleeping
- Heat intolerance
- Fever if so, how high? _____
- Diabetic

HEAD, NECK EARS, NOSE, THROAT

- Sinus infection/pain
- Ear pain
- Ringing in ears
- Change in hearing
- Eye pain
- Blurred vision
- Change in vision
- Nasal discharge
- Throat pain
- Stiff neck
- Lumps in neck

CARDIAC

- Chest pain
- Irregular heartbeat
- Shortness of breath on exertion
- Nighttime shortness of breath
- Fatigue
- Decrease in ability to exert oneself

RESPIRATORY

- Coughing up blood
- Cough or change in cough
- Mucous product with cough
- Shortness of breath when lying down
- Wheezing

PSYCHIATRIC

- Change in mood
- Change in behavior with family
- Change in ability to think
- Losing track of where one is, the time it is or who one is

HEMATOLOGIC

- Nosebleeds, easy bruising or bleeding at other sites

EXTREMITIES

- Redness of a limb
- Swelling of a limb, Discoloration of a limb
- Pain in legs when walking

GENITOURINARY

- Burning with urination
- Blood in urine
- Increase in need to urinate (day or night)
- Incontinence of urine
- Discharge from penis/vagina
- Pain with sexual intercourse
- Number of pregnancies

MUSCULOSKELETAL

- Arthritis
- Chronic back pain
- New back pain
- Bone pain
- Muscle soreness
- Recent trauma or fractures

SKIN

- Infections
- Ulcers
- Rashes

NEUROLOGICAL

- Headaches
- Change in ability to feel things
- Painful sensations
- Decrease in muscle strength
- Decrease in ability to ambulate
- Fainting
- Convulsions

GASTROINTESTINAL

- Pain or difficulty swallowing food
- Indigestion/Heartburn
- Nausea
- Vomiting
- Diarrhea
- Abdominal pain
- Black stools
- Blood from the rectum
- Constipation
- Incontinence of stool
- Food intolerance
- Jaundice (yellow skin or eyes)

PATIENT SIGNATURE _____

NEVADA SURGERY & CANCER CARE

AGE _____

NAME _____

DATE _____

Reason for Today's visit _____

GYN HISTORY (FEMALES ONLY)

Date of last period _____ Date of last Pap smear _____

Do you have a period every month? () Yes () No How many days? _____

Are your periods painful? () Yes () No Do you have bleeding between periods? () Yes () No

Do you have a history of abnormal Pap smears? () Yes () No Are you currently sexually active? () Yes () No

Do you desire more children? () Yes () No Do you use birth control? () Yes () No

Have you gone through menopause? () Yes () No Date of your last mammogram _____

OB HISTORY (FEMALES ONLY)

Number of pregnancies _____ (List all pregnancies, including those that ended in miscarriage/abortion)

Number of living children _____ Number of vaginal deliveries _____

List any medications, including herbal and vitamins, you currently take:

MEDICATION	DOSE	FREQUENCY

Please continue medication list on back of sheet if necessary

Medication allergies _____

MEDICAL HISTORY

	YES	NO		YES	NO
Blood clots in legs or lungs			Elevated blood pressure		
Cancer			Heart disease		
Uterus			Migraine headaches		
Colon			Osteoporosis		
Ovaries			Stroke		
Breast			Thyroid disease		
Cervix			Kidney disease		
Diabetes			Other		

Has an immediate family member had any of the above? () Yes () No If yes, what?

Have you ever had a colonoscopy? () Yes () No If so, when? _____

SURGICAL HISTORY

SURGERY	DATE	SURGERY	DATE

SOCIAL HISTORY

Do you smoke? () Yes () No If yes, how much? _____ Drink? () Yes () No

If yes, how much? _____ Recreational drugs? () Yes () No If yes, please list

NEVADA SURGERY & CANCER CARE

Lynn Kowalski, M. D.
Camille Falkner, M. D.
Richard Wasserman, M. D.

This is to inform all patients that our office will no longer be sending cards for normal Pap Smears. We will contact you by phone if you have an abnormal Pap Smear or a stable abnormality (no change from the previous Pap Smear).

Patient Signature _____

Date _____

Nevada Surgery and Cancer Care

*Lynn Kowalski, M.D.
Stephanie Wishnev, M.D.
Camille Falkner, M.D.
Richard Wasserman, M.D.*

Medical Records Release Form

I, _____ Hereby authorize

Dr. _____ at phone number _____

and fax number _____ to release my medical records to:

*Nevada Surgery and Cancer Care
3121 S Maryland Parkway Suite 600
Las Vegas, NV 89109*

Phone Number: (702) 739-6467

Fax Number: (702) 733-1689

Please release the following requested records:

Print Name: _____ Date: _____

Signature: _____ Date of Birth: _____

Social Security Number: _____

NEVADA SURGERY & CANCER CARE
3121 S MARYLAND PKWY STE 600
LAS VEGAS NV 89109
702-739-6467
702-733-1689 FAX

I, _____ authorize Nevada Surgery & Cancer Care to release medical information, in both written and verbal formats to the following individuals:

Name Relationship

Name Relationship

Name Relationship

Name Relationship

Print Patient Name

Signed

Date

NEVADA SURGERY & CANCER CARE

**LYNN KOWALSKI, M. D.
STEPHANIE WISHNEV, M. D.
CAMILLE FALKNER, M. D.
RICHARD WASSERMAN, M. D.**

**3121 S. Maryland Pkwy Suite 600
Las Vegas, NV 89109
Phone (702) 739-6467
Fax (702) 733-1689**

PRIVACY PRACTICES ACKNOWLEDGEMENT

I, _____ received the Notice of Privacy Practices
(Printed Patient Name)
and was given the opportunity to review it. The staff at Nevada Surgery &
Cancer Care explained the information I reviewed and I understand the
information provided.

Patient Signature _____ Date _____

Witness Signature _____ Date _____