# *The Casella Center for Advanced Gynecology, LLC*

**Peter J. Casella, MD FACOG**

**Patient Name:** _____ **Date of Birth:** _____

## Review of Symptoms

**In the last six (6) months, have you had any of the following symptoms?**

| Yes | No | |
|---|---|---|
| ___ | ___ | **Chest Pain** |
| ___ | ___ | **Dizziness** |
| ___ | ___ | **Chest discomfort when you walk** |
| ___ | ___ | **Skipped heart beats** |
| ___ | ___ | **Shortness of breath** |
| ___ | ___ | **Fainting Spells** |
| ___ | ___ | **Swelling ankles** |
| ___ | ___ | **Cramps in legs when you walk** |
| ___ | ___ | **Do you get regular exercise 3 or more times a week?** |
| ___ | ___ | **New cough** |
| ___ | ___ | **Wheezing in chest** |
| ___ | ___ | **Change in bowel habits** |
| ___ | ___ | **Blood in stool** |
| ___ | ___ | **Vomiting** |
| ___ | ___ | **Abdominal pain** |
| ___ | ___ | **Leakage of urine or wetting self with urine** |
| ___ | ___ | **Weak urinary stream** |
| ___ | ___ | **Getting up frequently at night to urinate** |
| ___ | ___ | **Change in mole** |
| ___ | ___ | **Persistent sore on skin** |
| ___ | ___ | **Persistent oral ulcer** |
| ___ | ___ | **Change in vision** |
| ___ | ___ | **Change in hearing** |
| ___ | ___ | **Change in sleep pattern** |
| ___ | ___ | **Episodes of numbness or weakness** |
| ___ | ___ | **Change in energy level** |
| ___ | ___ | **Loss of interest in activity** |
| ___ | ___ | **Trouble concentrating** |
| ___ | ___ | **Change in appetite** |
| ___ | ___ | **Do you feel safe at home?** |
| ___ | ___ | **Recent weight loss** |
| ___ | ___ | **Recent fevers** |
| ___ | ___ | **Recent pain or swelling in joints** |
| ___ | ___ | **Any recent swollen lymph glands** |
| ___ | ___ | **Any lumps or masses in the neck** |
| ___ | ___ | **Within the last year, did someone hit, slap, or physically hurt you?** |

_____ _____

**Patient Signature** **Date** **Physician Signature** **Date**

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