

**Surgery of London**  
Symptoms Questionnaire

Name: \_\_\_\_\_

**Symptoms:**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Weight loss         | <input type="checkbox"/> Rash                | <input type="checkbox"/> Swollen glands |
| <input type="checkbox"/> Poor appetite       | <input type="checkbox"/> Joint pain          | <input type="checkbox"/> Depression     |
| <input type="checkbox"/> Fatigue             | <input type="checkbox"/> Breast pain         | <input type="checkbox"/> Anxiety        |
| <input type="checkbox"/> Fever               | <input type="checkbox"/> Nipple discharge    | <input type="checkbox"/> Lethargy       |
| <input type="checkbox"/> Night sweats        | <input type="checkbox"/> Breast lump         | <input type="checkbox"/> Abdominal pain |
| <input type="checkbox"/> Headaches           | <input type="checkbox"/> Cough               | <input type="checkbox"/> Nausea         |
| <input type="checkbox"/> Dizziness           | <input type="checkbox"/> Wheezing            | <input type="checkbox"/> Vomiting       |
| <input type="checkbox"/> Visual changes      | <input type="checkbox"/> Chest pain          | <input type="checkbox"/> Diarrhea       |
| <input type="checkbox"/> Lightheadedness     | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Constipation   |
| <input type="checkbox"/> Heartburn           | <input type="checkbox"/> Jaundice            |   |
| <input type="checkbox"/> Pain with urination | <input type="checkbox"/> Blood in stool      |   |
| <input type="checkbox"/> Blood in urine      | <input type="checkbox"/> Bloating            |   |

**Other Symptoms:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Social History:**

Married:  Yes  No      Tobacco:  Yes  No      ppd \_\_\_\_\_ yrs \_\_\_\_\_  
Number of children: \_\_\_\_\_      Alcohol:  Yes  No      drinks per week \_\_\_\_\_  
Occupation: \_\_\_\_\_      Caffeine:  Yes  No      cups per day \_\_\_\_\_

When was your last chest X-ray and/or EKG? \_\_\_\_\_

\_\_\_\_\_ Doctor Initials  
\_\_\_\_\_ Date

**Female Patients Only:**

Past breast problems: \_\_\_\_\_  
Past breast surgery: \_\_\_\_\_  
Date of last mammogram: \_\_\_\_\_  
Number of children: \_\_\_\_\_ Did you breast feed? Y N Age at first delivery: \_\_\_\_\_  
Age at first period: \_\_\_\_\_ Age at menopause: \_\_\_\_\_  
Do you take birth control pills or hormone replacement therapy? Y N If yes, how many years? \_\_\_\_\_

\_\_\_\_\_ Doctor Initials  
\_\_\_\_\_ Date

