Peter J Campbell, MD
Josh C Vella, MD
Hand Surgery Consultants

Name: ______________________________ PID#: ____________
Last First MI (Office Use Only)

OTHER SYMPTOMS OR AREAS OF YOUR BODY THAT ARE BOTHERING YOU (please circle):

NEURO:	headache—convulsions—seizures—fainting—A.D.D.—stroke Other: ____________	NONE
PSYCHIATRIC:	depression—anxiety—stress/excess worry—drug/alcohol issues Other: ____________	NONE
EYES:	visual problem—blurry vision—red eyes Other: ____________	NONE
NOSE:	nasal allergies—nose bleeds Other: ____________	NONE
THROAT:	swallowing difficulty—frequent sore throats—speech problems Other: ____________	NONE
MOUTH:	dental problems—tongue problems—canker sores Other: ____________	NONE
NECK:	swollen glands—thyroid problems Other: ____________	NONE
CHEST:	chest pain—asthma—shortness of breath—cough—TB Other: ____________	NONE
HEART:	murmurs—palpitations—valve problems—mitral valve prolapse—angina Other: ____________	NONE
INTESTINAL:	colitis—ulcer gastritis—Barrett's esophagus—polyps—constipation Other: ____________	NONE
URINARY:	urinary problems—urinary frequency—burning—kidney stones Other: ____________	NONE
GENITAL:	infection—warts—herpes—impotence—sexual difficulty Other: ____________	NONE
UPPER EXTREMITY:	shoulder pain—elbow pain—wrist pain—numbness—stiffness—swelling Other: ____________	NONE
LOWER EXTREMITY:	knee pain—hip pain—ankle pain—tingling—numbness Other: ____________	NONE
SPINE:	low back pain—neck pain—mid back pain—scoliosis—herniated disc—sciatica Other: ____________	NONE
SYSTEMIC:	weight loss—fever—night sweats—trouble sleeping—loss of energy—arthritis Other: ____________	NONE
SKIN:	rash—itching—change in color Other: ____________	NONE

Patient Signature: ______________________________ Date: ____________
(or Parent Signature if applicable)

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