MENARD

PLASTIC SURGERY

REVIEW OF SYSTEMS

Have you had recent onset of any of the following?

GENERAL HEALTH

CURRENT WEIGHT _____ HEIGHT_____

YES_____ NO_____ WEIGHT GAIN OR WEIGHT LOSS
YES_____ NO_____ FATIGUE/LACK OF ENERGY
YES_____ NO_____LOSS OF APPETITE

EARS, NOSE, MOUTH, THROAT

YES_____ NO_____HEADACHE
YES_____ NO_____FACIAL PAIN
YES_____ NO_____HEARING LOSS
YES_____ NO_____NECK PAIN
YES_____ NO_____VISUAL CHANGES

HEART & BLOOD VESSELS

YES_____ NO_____CHEST PAIN
YES_____ NO_____IRREGULAR HEARTBEAT
YES_____ NO_____SWELLING OF FEET OR LEGS

LUNGS & BREATHING

YES_____ NO_____SHORTNESS OF BREATH
YES_____ NO_____COUGH
YES_____ NO_____USE OF HOME 02
YES_____ NO_____USE OF CPAP

STOMACH & INTESTINES

YES_____ NO_____ABDOMINAL PAIN
YES_____ NO_____NAUSEA/VOMITING
YES_____ NO_____APPETITE CHANGES

PYSCHOLOGICAL

YES_____ NO_____ANXIETY
YES_____ NO_____DEPRESSION
YES_____ NO_____MENTAL HEALTH ISSUES

NEUROLOGICAL

YES_____ NO_____SYNCOPE
YES_____ NO_____DIZZINESS

SKIN & BREAST

YES_____ NO_____NIPPLE DISCHARGE
YES_____ NO_____BREAST PAIN
YES_____ NO_____BREAST LUMP