BAY AREA HEART
Cardiovascular Center of Excellence

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ESTABLISHED PATIENT REVIEW OF SYSTEMS

Please complete the information below by indicating if you do or do not have any symptoms. To make your visit to our office faster and more efficient, we ask that ***you fill out this review of systems on every visit***. ***Please bubble in yes or no*** and be sure to fill in completely. Your cooperation is much appreciated and will help make your visit go a lot quicker. Thank you for your time and patience in this matter.

NAME:_____ **DATE of BIRTH:** _____

General/Constitutional

Chills	O Yes	O No
Fever	O Yes	O No
Fatigue	O Yes	O No
Change in appetite	O Yes	O No
Weight gain	O Yes	O No
Weight loss	O Yes	O No

ENT

Difficulty swallowing	O Yes	O No
Sore throat	O Yes	O No

Respiratory

Cough	O Yes	O No
Pain with deep breath	O Yes	O No
Shortness of breath	O Yes	O No
Wheezing	O Yes	O No
Coughing up blood	O Yes	O No

Cardiovascular

Chest pain at rest	O Yes	O No
Chest pain w/ exercise	O Yes	O No
trouble laying flat	O Yes	O No
Dizziness	O Yes	O No
Swelling of legs	O Yes	O No
Swelling in hands/feet	O Yes	O No
Irregular heartbeat	O Yes	O No
Palpitations	O Yes	O No
Weakness	O Yes	O No

Hematology

Easy bruising	O Yes	O No
Prolonged bleeding	O Yes	O No

Gastrointestinal

Abdominal pain	O Yes	O No
Change in bowel habits	O Yes	O No
Nausea	O Yes	O No
Vomiting	O Yes	O No

Neurologic

Headache	O Yes	O No
Loss of strength	O Yes	O No
Memory loss	O Yes	O No
Tingling/Numbness	O Yes	O No
Tremor	O Yes	O No
momentary loss of vision	O Yes	O No

Peripheral Vascular

Cold extremities	O Yes	O No
Ulceration of feet	O Yes	O No
Painful extremities	O Yes	O No

EMAIL: _____

FAMILY PHYSICIAN/PCP:

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