BAY AREA HEART
Cardiovascular Center of Excellence

REVIEW OF SYSTEMS

NAME: ____

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 loss	O Yes	O No
Weight gain	O Yes	O No
Lightheadedness	O Yes	O No

ENT

Dry mouth	O Yes	O No
Difficulty swallowing	O Yes	O No
Sore throat	O Yes	O No

Hematology

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

Musculoskeletal

Leg cramps	O Yes	O No
Muscle aches	O Yes	O No
Joint stiffness	O Yes	O No

Peripheral Vascular

Decreased feeling in legs	O Yes	O No
Cold extremities	O Yes	O No

Cardiovascular

Chest pain at rest	O Yes	O No
Chest pain w exercise	O Yes	O No
Difficulty laying flat	O Yes	O No
Swelling of legs	O Yes	O No
Irregular heartbeat	O Yes	O No
Palpitations	O Yes	O No
Swelling in hands	O Yes	O No

Respiratory

Cough	O Yes	O No
Wheezing	O Yes	O No
Shortness of breath	O Yes	O No
Pain w deep breaths	O Yes	O No

Gastrointestinal

Abdominal pain	O Yes	O No
Change in bowel habits	O Yes	O No
Constipation	O Yes	O No
Diarrhea	O Yes	O No
Heartburn	O Yes	O No
Nausea	O Yes	O No

Genitourinary

Difficulty urinating	O Yes	O No
Frequent urination	O Yes	O No
Painful urination	O Yes	O No

Neurologic

Dizziness	O Yes	O No
Headache	O Yes	O No
Memory loss	O Yes	O No
Low back pain	O Yes	O No
Tingling/Numbness	O Yes	O No

Psychiatric

Anxiety	O Yes	O No
Depressed mood	O Yes	O No