Coastal Cardiothoracic & Vascular Associates
Review of Systems

□ New Patient	□ Established Patient	□ Consultation

Date: _____ Name: _____ DOB: _____

Describe the reason for your visit today: _____

_____

List medications including herbal: _____

_____

_____

_____

Allergies: □ None □ Yes Please List: _____ Latex Allergy: □ Yes □ No

REVIEW OF SYSTEMS

Please Check Off All That Apply

General
□ Weight Loss/Gain
□ Fever
□ Fatigue
□ Loss of Appetite
□ None of the above

Eyes
□ Vision Change
□ Glasses/Contacts
□ Cataracts
□ Blurred Vision
□ Other: _____
□ None of the above

Ear Nose Throat
□ Bloody Nose
□ Ringing in Ears
□ Pain with Swallowing
□ Hoarseness
□ Snoring
□ Hearing Loss/Aides
□ Dentures
□ Other: _____
□ None of the above

Endocrine
□ Diabetes
□ Thyroid Problems
□ None of the above

Cardiovascular
□ High Blood Pressure
□ Murmur
□ Chest Pain
□ Angina
□ High Cholesterol
□ Irregular Heartbeat
□ Scarlet Fever
□ Rheumatic Fever
□ Heart Fever
□ Heart Attack
□ Stroke
□ Varicose Veins
□ Other: _____
□ None of the above

Respiratory
□ Wheezing
□ Asthma
□ Cough
□ Pneumonia
□ Shortness of Breath
□ COPD
□ Emphysema
□ TB
□ Blood Clots
□ Other: _____
□ None of the above

Gastrointestinal
□ Diarrhea
□ Bloody Stools
□ Abdominal Pain
□ Nausea/Vomiting
□ Constipation
□ Ulcers
□ Other: _____
□ None of the above

Genitourinary
□ Urgency w/urination
□ Frequency
□ Blood in urine
□ Incontinence
□ Kidney Stones
□ Other: _____
□ None of the above

Musculoskeletal
□ Muscle Weakness
□ Swelling
□ Cramping/Cool Extremities
□ Bruise easily
□ Other: _____
□ None of the above

Skin
□ Rashes
□ Lesions
□ Ulcers
□ None of the above

Neurological
□ Headache/Migraine
□ Seizures
□ Fainting
□ Other: _____
□ None of the above

Psychiatric
□ Depression
□ Mood changes
□ Anxiety
□ Other: _____
□ None of the above

Hemat/Lymph
□ Bleeding Tendency
□ Hepatitis
□ HTV
□ Anemia
□ Other: _____
□ None of the above

Coastal Cardiothoracic & Vascular Associates

Review of Systems

Date: _____ Name: _____ DOB: _____

Previous Surgeries: _____

_____

Family History:

□ Asthma □ Cancer □ Coronary Artery Disease □ Diabetes □ Heart Attack/Stroke □ High Blood Pressure

Social History:

Marital Status: □ Married □ Single □ Widowed

Employed: □ Yes □ No Occupation: _____

Do you or have you smoked? □ Yes □ No □ Cigarettes □ Pipe □ Cigars □ Other _____

Number of years? _____ How much? _____

Do you regularly drink alcohol? □ Yes □ No How many per day? _____

Illicit Drug Use □ Yes □ No Type: _____

Living Situation/Arrangement: _____

I verify that the information listed above is true and accurate to the best of my ability.

Weight: _____ Blood Pressure □ Rt _____□ Lt _____ □ Sitting □ Standing Temp.: _____ Pulse: _____

_____ _____

Patient Signature Date

MA/Nurse Signature: _____ Date: _____

Printed Name: _____

Physician Signature: _____ Date: _____

Printed Name: _____