Southwest CVA
Cardiovascular Associates

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02 - PATIENT CURRENT SYMPTOMS - REVIEW OF SYSTEMS

*Do you **currently have or recently have had any** of the following symptoms?*

CARDIOVASCULAR		
High Blood Pressure	Yes	No
Heart Murmur	Yes	No
Chest Discomfort	Yes	No
Fluttering Feeling in Chest	Yes	No
Skipped Heartbeats	Yes	No
Swelling in Ankles/Feet	Yes	No
Varicose Veins	Yes	No
CONSTITUTIONAL		
Significant Weight Loss	Yes	No
Significant Weight Gain	Yes	No
Night Sweats	Yes	No
Unexplained Fever	Yes	No
ENDOCRINE		
Thyroid Problem	Yes	No
EAR/NOSE/MOUTH/THROAT		
Difficulty Swallowing	Yes	No
Dry, Hoarse Throat	Yes	No
EYES		
Blurred/Double Vision	Yes	No
Cataracts	Yes	No
Glaucoma	Yes	No
GASTROINTESTINAL		
Indigestion/Nausea	Yes	No
Ulcers	Yes	No
Diarrhea	Yes	No
Constipation	Yes	No
Abdominal Pain	Yes	No
GENITOURINARY		
Loss of Bladder Control	Yes	No
Blood in Urine	Yes	No

HEMATOLOGY/LYMPHATIC		
Breast Masses/Lumps	Yes	No
Enlarged Lymph Nodes	Yes	No
Unexplained Bruising	Yes	No
INTEGUMENTARY		
Skin Rash	Yes	No
MUSCULOSKELETAL		
Arthritis	Yes	No
Back Pain	Yes	No
Muscle Weakness	Yes	No
Leg Pain	Yes	No
NEUROLOGICAL		
Headaches/Migraines	Yes	No
Memory Loss	Yes	No
Speech Problems	Yes	No
Dizziness/Fainting Spells	Yes	No
Stroke	Yes	No
PSYCHOLOGICAL		
Depression	Yes	No
Anxiety	Yes	No
High/Unusual Stress	Yes	No
Eating Disorder	Yes	No
RESPIRATORY		
Asthma	Yes	No
Emphysema	Yes	No
Chronic Cough	Yes	No
Wheezing	Yes	No
Shortness of Breath	Yes	No
History of Tuberculosis	Yes	No
Valley Fever	Yes	No
Lung Disease	Yes	No

PATIENT NAME ______________________   DATE ____________