Review of Systems

MEMORIAL HEALTH CARDIOVASCULAR & THORACIC SURGERY

Patient Name: _____ Date: _____

Have you had any of the following symptoms lately?

General

Fatigue	◯ Yes	◯ No
Fever	◯ Yes	◯ No
Weight loss	◯ Yes	◯ No
Chills	◯ Yes	◯ No

Eyes

Blurred vision	◯ Yes	◯ No
Vision changes	◯ Yes	◯ No

Ears

Ear pain	◯ Yes	◯ No
Hearing loss	◯ Yes	◯ No

Nose and Throat

Nasal congestion	◯ Yes	◯ No
Bloody nose	◯ Yes	◯ No

Lungs

Shortness of breath	◯ Yes	◯ No
Cough	◯ Yes	◯ No
Wheezing	◯ Yes	◯ No

Heart

Chest pain	◯ Yes	◯ No
Shortness of breath while sleeping	◯ Yes	◯ No

Breasts

Drainage from nipple	◯ Yes	◯ No
Breast lump	◯ Yes	◯ No

Gastrointestinal

Nausea	◯ Yes	◯ No
Vomiting	◯ Yes	◯ No
Changes in bowels	◯ Yes	◯ No
Diarrhea	◯ Yes	◯ No
Constipation	◯ Yes	◯ No
Blood in stool	◯ Yes	◯ No

Urinary

Frequent urination	◯ Yes	◯ No
Painful urination	◯ Yes	◯ No
Blood in urine	◯ Yes	◯ No
Urinary leakage	◯ Yes	◯ No

Hematologic

Bruises easily	◯ Yes	◯ No
Prolonged bleeding	◯ Yes	◯ No

Musculoskeletal

Joint pain	◯ Yes	◯ No
Muscle pain	◯ Yes	◯ No
Back pain	◯ Yes	◯ No

Skin

Skin rash	◯ Yes	◯ No
Itching	◯ Yes	◯ No

Neurological

Headache	◯ Yes	◯ No
Dizziness	◯ Yes	◯ No
Numbness	◯ Yes	◯ No

Psychiatric

Difficulty sleeping	◯ Yes	◯ No
Feeling anxious	◯ Yes	◯ No
Feeling depressed	◯ Yes	◯ No

Endocrine

Intolerant of cold	◯ Yes	◯ No
Intolerant of heat	◯ Yes	◯ No