CARDIASTREAM
We Keep Life Flowing
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CHRISTUS® TRINITY MOTHER FRANCES
Louis and Peaches Owen Heart Hospital
Tyler

ROS (Review of Systems)

Patient Name: ______________________________ **Date of Visit:** ______________________________

Date of Birth: ______________________________

PLEASE ASK QUESTIONS REGARDING THIS FORM TO THE MEDICAL PERSONNEL WHEN YOU ARE CALLED INTO A ROOM

Vein Questions (Please check Yes or No)	**YES**	**NO**
History of Varicose Veins?	☐	☐
Discomfort in your legs at rest or while standing?	☐	☐
Discomfort in your thighs, legs or buttocks while walking (claudication)?	☐	☐
Do you have sores on your toes or feet?	☐	☐
Do you have a Pacemaker or Defibrillator? If yes, last checked______________	☐	☐

ROS - Have you had recently or are you presently experiencing? (Please check Yes or No)		**YES**	**NO**
Diaphoresis	Do you break out in a sweat with light exertion or at rest?	☐	☐
Fever	Have you had a recent fever?	☐	☐
Weight Gain	Any unexplained weight gain?	☐	☐
Weight loss	Any unexplained weight loss?	☐	☐
Visual Disturbance	Have you had any recent or new vision problems?	☐	☐
Hemoptysis	Do you notice any blood when you cough?	☐	☐
Shortness of Breath	Shortness of breath or difficulty breathing at rest or light activity?	☐	☐
Snoring	Has anyone ever told you that you snore?	☐	☐
Hearing Loss	Do you wear a hearing aid or have any difficulty hearing?	☐	☐
Chest Pain	Have you had any recent chest pain or pressure at rest or with exercise?	☐	☐
Dyspnea with Exertion	Do you have shortness of breath brought on by physical activity?	☐	☐
Leg Swelling	Any swelling in your ankles, feet or legs?	☐	☐
Orthopnea	Difficulty breathing while lying flat and improves when you sit up?	☐	☐
Palpitations	Do you experience any irregular, hard or rapid heart beats?	☐	☐
PND	Do you wake up from sleep short of breath or gasping for air?	☐	☐
Syncope	Have you fainted or had a recent fall with a brief loss of consciousness?	☐	☐
Bleeding	Any unusual bleeding from your stomach or bowels?	☐	☐
Easy Bruising	Do you bruise or bleed easily?	☐	☐
Joint Pain	Do you have any joint pain, soreness or stiffness?	☐	☐
Myalgia	Do you have any muscle pain or tenderness?	☐	☐
Heartburn	Do you experience heartburn?	☐	☐
Nausea	Do you have any nausea or upset stomach?	☐	☐
Hematuria	Have you seen any blood in your urine?	☐	☐
Nocturia	Do you wake up more than twice a night to urinate?	☐	☐
Dizziness	Have you had any dizziness or lightheadedness?	☐	☐
Seizures	Have you had a recent seizure?	☐	☐
Depression	Do you have treated or untreated depression	☐	☐
Memory Loss	Do you have any short term or long term memory problems?	☐	☐

TO BE FILLED OUT BY MEDICAL PERSONNEL		**VITAL SIGNS**	
Left sitting	BP:	HR:	Weight:
Left standing	BP:	HR:	Height:
Right sitting	BP:	HR:	O2 sat: