

TEXAS VASCULAR ASSOCIATES, PA

TODAY'S DATE: _____

PATIENT NAME: _____

PATIENT DATE OF BIRTH: _____

PHYSICIAN NAME: _____

REVIEW OF SYSTEMS (ROS)

ARE YOU EXPERIENCING ANY OF THE FOLLOWING

(CIRCLE YES OR NO)

<u>General</u>		<u>Eyes</u>		<u>ENT</u>		<u>Gastrointestinal</u>	
Weight gain	Y N	Pain	Y N	Sore Throat	Y N	Abdominal Pain	Y N
Weight Loss	Y N	Discharge	Y N	Hoarseness	Y N	Nausea	Y N
Fever	Y N	Light Sensitivity	Y N	Ringing in Ears	Y N	Vomiting	Y N
Chills	Y N	Blurred Vision	Y N	Nose Bleeds	Y N	Diarrhea	Y N
Fatigue	Y N	Double Vision	Y N	Hearing Loss	Y N	Constipation	Y N
Loss of Appetite	Y N	Other _____		Other _____		Heartburn	Y N
Night Sweats	Y N					Blood in Stool	Y N
Other _____						Other _____	

<u>Cardiovascular</u>		<u>Genitourinary</u>		<u>Musculoskeletal</u>		<u>Skin/Breast</u>	
Chest Pain	Y N	Frequency	Y N	Muscle Pain	Y N	Rash	Y N
Palpitations	Y N	Incontinence	Y N	Joint Pain	Y N	Moles	Y N
Calf Pain	Y N	Flank Pain	Y N	Joint Swelling	Y N	Sores	Y N
Leg Pain	Y N	Blood in Urine	Y N	Weakness	Y N	Breast Discharge	Y N
Shortness of Breath	Y N	Other _____		Poor Balance	Y N	Other _____	
Other _____				Other _____			

<u>Respiratory</u>		<u>Hematological</u>		<u>Endocrine</u>		<u>Psychological</u>	
Wheeze	Y N	Easy Bruising	Y N	Excessive Sweating	Y N	Anxiety	Y N
Cough	Y N	Swollen Glands	Y N	Excessive Thirst	Y N	Depression	Y N
Bloody Sputum	Y N	Excessive Bleeding	Y N	Excessive Heat	Y N	Stress	Y N
Other _____		Other _____		Excessive Cold	Y N	Other _____	
				Other _____			

<u>Neurological</u>		<u>Explanation or Other Symptoms</u>
Headaches	Y N	_____
Confusion	Y N	_____
Dizziness	Y N	_____
Memory Loss	Y N	_____
Seizure	Y N	_____
Other _____		_____