Cardiothoracic and Vascular Surgeons - Review Of Systems (ROS)

(please check all the following conditions listed below that you are currently experiencing. If applicable, provide additional notes about the condition)

Patient Name_____ **Patient D.O.B.**_____ **Date**_____ **Athena #** _____
(for staff only)

Constitutional ☐**NONE or:** ☐fever ☐night sweats ☐significant weight gain ☐significant weight loss ☐exercise intolerance
Additional Notes:_____

Eyes ☐**NONE or:** ☐dry eyes ☐eye irritation ☐vision changes ☐needs glasses/contacts
Additional Notes:_____

Ears ☐**NONE or:** ☐difficulty hearing ☐ear pain
Additional Notes:_____

Nose ☐**NONE or:** ☐frequent nosebleeds ☐sinus problems ☐nose problems
Additional Notes:_____

Mouth/Throat ☐**NONE or:** ☐sore throat ☐bleeding gums ☐snoring ☐dry mouth ☐mouth ulcers ☐oral abnormalities ☐teeth problems
Additional Notes:_____

Cardiovascular ☐**NONE or:** ☐chest pain ☐arm pain on exertion ☐shortness of breath when walking ☐shortness of breath when lying down ☐palpitations ☐heart murmur ☐chest pain on exertion ☐light-headed upon standing
Additional Notes:_____

Respiratory ☐**NONE or:** ☐cough ☐wheezing ☐shortness of breath ☐coughing up blood ☐sleep apnea
Additional Notes:_____

Gastrointestinal ☐**NONE or:** ☐abdominal pain ☐vomiting ☐abnormal appetite ☐diarrhea ☐vomiting blood ☐change in appetite ☐black or tarry stools
Additional Notes:_____

Genitourinary ☐**NONE or:** ☐difficulty urinating ☐increased frequency of urination ☐blood in urine ☐loss of bladder control ☐incomplete emptying of bladder ☐decrease of urinary output
Additional Notes: _____

Musculoskeletal ☐**NONE or:** ☐muscle aches ☐muscle weakness ☐joint pain ☐back pain ☐swelling in the extremities ☐needs wheelchair ☐needs walker
Additional Notes:_____

Neurologic ☐**NONE or:** ☐loss of consciousness ☐weakness ☐numbness ☐seizures ☐dizziness ☐headaches ☐frequent/severe headaches ☐migraines ☐restless legs
Additional Notes:_____

Endocrine ☐**NONE or:** ☐fatigue ☐increased thirst ☐hair loss ☐increased hair growth ☐cold intolerance
Additional Notes:_____

Hematologic/ Lymphatic ☐**NONE or:** ☐swollen glands ☐bruising ☐excessive bleeding
Additional Notes:_____

Allergic/ Immunologic ☐**NONE or:** ☐runny nose ☐sinus pressure ☐itching ☐hives ☐frequent sneezing
Additional Notes:_____