

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)

<u>Constitutional</u>	<input type="checkbox"/> NONE or: <input type="checkbox"/> fever <input type="checkbox"/> night sweats <input type="checkbox"/> significant weight gain <input type="checkbox"/> significant weight loss <input type="checkbox"/> exercise intolerance <input type="checkbox"/> fatigue Comments _____
<u>Eyes</u>	<input type="checkbox"/> NONE or: <input type="checkbox"/> dry eyes <input type="checkbox"/> eye irritation <input type="checkbox"/> vision changes <input type="checkbox"/> difficulty reading: needs glasses/contacts Comments _____
<u>Ears</u>	<input type="checkbox"/> NONE or: <input type="checkbox"/> difficulty hearing <input type="checkbox"/> ear pain Comments _____
<u>Nose</u>	<input type="checkbox"/> NONE or: <input type="checkbox"/> frequent nosebleeds <input type="checkbox"/> nose/sinus problems Comments _____
<u>Mouth/Throat</u>	<input type="checkbox"/> NONE or: <input type="checkbox"/> sore throat <input type="checkbox"/> bleeding gums <input type="checkbox"/> snoring <input type="checkbox"/> dry mouth <input type="checkbox"/> mouth ulcers <input type="checkbox"/> oral abnormalities <input type="checkbox"/> teeth problems Comments _____
<u>Cardiovascular</u>	<input type="checkbox"/> NONE or: <input type="checkbox"/> chest pain <input type="checkbox"/> chest pain on exertion <input type="checkbox"/> shortness of breath when walking <input type="checkbox"/> shortness of breath when lying down <input type="checkbox"/> palpitations <input type="checkbox"/> known heart murmur <input type="checkbox"/> lightheadedness Comments _____
<u>Respiratory</u>	<input type="checkbox"/> NONE or: <input type="checkbox"/> cough <input type="checkbox"/> wheezing <input type="checkbox"/> shortness of breath <input type="checkbox"/> coughing up blood <input type="checkbox"/> sleep disturbances (sleep apnea) Comments _____
<u>Gastrointestinal</u>	<input type="checkbox"/> NONE or: <input type="checkbox"/> abdominal pain <input type="checkbox"/> vomiting <input type="checkbox"/> abnormal appetite <input type="checkbox"/> diarrhea <input type="checkbox"/> vomiting blood <input type="checkbox"/> black or tarry stools Comments _____
<u>Genitourinary</u>	<input type="checkbox"/> NONE or: <input type="checkbox"/> incontinence (loss of urinary control) <input type="checkbox"/> difficulty urinating <input type="checkbox"/> increased urinary frequency <input type="checkbox"/> hematuria <input type="checkbox"/> change in urinary output <input type="checkbox"/> incomplete emptying of bladder Comments _____
<u>Musculoskeletal</u>	<input type="checkbox"/> NONE or: <input type="checkbox"/> muscle aches <input type="checkbox"/> muscle weakness <input type="checkbox"/> arthralgias/joint pain <input type="checkbox"/> back pain <input type="checkbox"/> swelling in the extremities <input type="checkbox"/> needs wheelchair <input type="checkbox"/> needs walker Comments _____
<u>Neurologic</u>	<input type="checkbox"/> NONE or: <input type="checkbox"/> loss of consciousness <input type="checkbox"/> weakness <input type="checkbox"/> numbness <input type="checkbox"/> seizures <input type="checkbox"/> dizziness <input type="checkbox"/> frequent/severe headaches <input type="checkbox"/> migraines <input type="checkbox"/> restless legs Comments _____
<u>Hematologic/ Lymphatic</u>	<input type="checkbox"/> NONE or: <input type="checkbox"/> swollen glands <input type="checkbox"/> bruising <input type="checkbox"/> easy / excessive bleeding tendency Comments _____
<u>Allergic/ Immunologic</u>	<input type="checkbox"/> NONE or: <input type="checkbox"/> runny nose <input type="checkbox"/> sinus pressure <input type="checkbox"/> itching <input type="checkbox"/> hives <input type="checkbox"/> frequent sneezing Comments _____
<u>Endocrine</u>	<input type="checkbox"/> NONE or: <input type="checkbox"/> excessive thirst or water consumption <input type="checkbox"/> overall weakness <input type="checkbox"/> excessive facial or body hair growth <input type="checkbox"/> temperature intolerance Comments _____
<u>Lung Symptoms</u> <i>Check the lung symptoms that you are currently having or have had.</i>	<input type="checkbox"/> NONE or: <input type="checkbox"/> Cough <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Bronchitis <input type="checkbox"/> Enlarged Lymph Nodes <input type="checkbox"/> Chronic pulmonary heart disease (enlarged heart area from pumping/working harder) <input type="checkbox"/> Atherosclerosis of aorta (plaque build up in major heart artery) <input type="checkbox"/> Mucopurulent (yellow/green mucus) Chronic Bronchitis <input type="checkbox"/> Chronic Airway Obstruction (airways often congested/tight feeling) <input type="checkbox"/> Hemoptysis (coughing up blood/bloody sputum) <input type="checkbox"/> Other Chest Pain <input type="checkbox"/> Tachypnea (very rapid breathing) <input type="checkbox"/> Swelling mass/lump-Chest <input type="checkbox"/> Abnormal Chest Sounds (popping, rattling, crackling chest sounds) <input type="checkbox"/> Abnormal Electrocardiogram (EKG) Comments _____