Patient Name: ______________________________ **Date:** ____________________

Cardiologist: ____________________________ **Primary Care:** __________________

Heart Center of North Texas
Quick Review of Systems

Please mark each item that apply for **TODAY'S** visit **only** or that may be a recent (2-3 weeks) onset of symptoms. If "yes", please explain briefly, the doctor will discuss this with you in more detail.

If YES please circle the appropriate symptoms:

		Y	N	Explain
Cardiac:	Chest Pain	☐	☐	
	Irregular/fast heart beat	☐	☐	
	Sweating	☐	☐	
	Passing out	☐	☐	
	Difficulty breathing	☐	☐	
	Difficult breathing @ night	☐	☐	
Vascular:	Leg pain with walking	☐	☐	
	Swollen feet/ankles	☐	☐	
Body related:	Weight gain _____lbs	☐	☐	
	Weight loss ______lbs	☐	☐	
	Unexplained fever	☐	☐	
Head/eyes/ears/nose/	Vision changes	☐	☐	
Throat:	Hearing loss, nose bleeds	☐	☐	
Lungs:	Snoring, cough with blood	☐	☐	
	Shortness of Breath	☐	☐	
Stomach:	Nausea, bleeding or reflux	☐	☐	
Urinary:	Blood in urine	☐	☐	
	Frequent urination @ night	☐	☐	
Neurological:	Dizzy, Memory loss	☐	☐	
	Seizures	☐	☐	
Psychiatric:	Depression Hallucinations	☐	☐	
Blood disorders:	Severe Anemia	☐	☐	
	Low Platelets	☐	☐	
	Bruising, bleeding, clots	☐	☐	
Reproductive:	Erectile Dysfunction	☐	☐	
	History Oral Contraceptives	☐	☐	
Endocrine:	Thyroid Goiter	☐	☐	
	Tremors	☐	☐	
Skin:	Rash, skin sores	☐	☐	
Musculoskeletal:	Joint pain	☐	☐	
	Muscle Aches	☐	☐	
Other:				

Have you had recent Lab work? Yes No Where? ______________________

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