Cardiology Consultants

Patient Name: _____ Date of Birth: _____ Date: _____

Review of Systems (please check if you have any of the following)

General

- ☐ Daytime sleepiness
- ☐ Weakness
- ☐ Weight Gain
- ☐ Weight Loss

Cardiovascular

- ☐ Chest pain
- ☐ Fainting
- ☐ Heart racing (palpitations)
- ☐ Swelling in feet/legs (peripheral)

Respiratory

- ☐ Cough
- ☐ Excessive snoring
- ☐ Shortness of breath
- ☐ Wheezing

Neurologic

- ☐ Dizziness (lightheadedness)
- ☐ Morning headaches

Gastro-Intestinal

- ☐ Constipation
- ☐ Diarrhea
- ☐ Bloody stools
- ☐ Indigestion
- ☐ Dark tarry stools
- ☐ Nausea
- ☐ Vomiting

Genital-Urinary

- ☐ Difficult urination (dysuria)
- ☐ Blood in urine (hematuria)

Musculo-Skeletal

- ☐ Leg pain
- ☐ Muscle cramps

Dermatologic

- ☐ Non-healing ulcer
- ☐ Scar to chest
- ☐ Scar to leg

Ears, Nose, Throat

- ☐ Hoarseness
- ☐ Nosebleed

Psychiatric

- ☐ Anxiety
- ☐ Depression

Allergies

- ☐ Allergic to dye
- ☐ Allergic to iodine
- ☐ Allergic to medications
- ☐ Allergic to shellfish

Form Completed By

Physician Signature