GREENVILLE HEALTH SYSTEM

Arrhythmia Consultants: Comprehensive Review of Symptoms

Patient Name: _____ DOB: _____
Date: _____

PLEASE INDICATE ANY RECENT PROBLEMS. USE THE SPACE PROVIDED IF NEEDED.

Constitutional: ☐fever ☐chills ☐night sweats ☐fatigue ☐weakness ☐loss of appetite ☐weight loss

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Eye: ☐vision loss ☐vision change ☐cataracts ☐glaucoma

ENT: ☐hoarseness ☐difficulty swallowing ☐hearing loss ☐nose bleeds

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Cardiovascular: ☐chest pain ☐shortness of breath ☐palpitations ☐passing out ☐shortness of breath with exertion ☐difficulty breathing lying flat ☐waking up at night short of breath ☐swelling ☐dizziness

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Respiratory: ☐cough ☐shortness of breath ☐coughing up blood ☐wheezing ☐snoring ☐sleep apnea

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Gastrointestinal: ☐nausea ☐vomiting ☐constipation ☐hiatal hernia ☐bloody stools ☐diarrhea ☐indigestion/reflux ☐abdominal pain ☐jaundice

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Musculoskeletal: ☐back pain ☐muscle cramps ☐joint pain ☐muscle pain ☐arthritis

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Skin: ☐rashes ☐skin growths

Neurological: ☐fainting ☐headaches ☐memory loss ☐seizures ☐stroke ☐paralysis ☐numbness ☐poor balance ☐dizziness

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Psychiatric: ☐depression ☐anxiety ☐panic attacks

Endocrine: ☐diabetes ☐thyroid problems

Hematology/Lymphatic: ☐anemia ☐blood transfusions ☐blood disorder ☐abnormal bruise ☐blood in urine

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Allergic/Immunologic: ☐food/insect/seasonal allergies ☐difficulty breathing due to allergic reaction ☐passing out due to allergic reaction

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