GREENVILLE HEALTH SYSTEM
Carolina Cardiology Consultants

Comprehensive Review of Systems

Please bring this form to your appointment.

Patient name: _____

SS#: _____ Date: _____

Please indicate any recent problems. Use the space provided if needed.

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

---

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

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

---

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

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

---

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

Genitourinary: ☐ difficult/painful urination ☐ blood in urine

---

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

---

Skin: ☐ rashes ☐ skin growths

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

Psychiatric: ☐ depression ☐ anxiety ☐ panic attacks

Endocrine: ☐ diabetes ☐ thyroid problems

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

---

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