ATLANTA HEART SPECIALISTS – REVIEW OF SYSTEMS (to be filled out if not done in the past 3 months)

NAME ______________________________ **DATE** ______________________

PLEASE INDICATE BELOW. ARE YOU **CURRENTLY** EXPERIENCING ANY OF THESE SYMPTOMS:

General, constitutional

Symptom		
Good general health lately	no	yes
Recent weight change	no	yes
Fever / chills	no	yes
Fatigue	no	yes

Eyes and vision

Symptom		
Eye disease or injury	no	yes
Wear glasses or contact lenses	no	yes
Blurred or double vision	no	yes
Glaucoma	no	yes

Ears, nose, throat

Symptom		
Hearing loss	no	yes
Ringing in the ears	no	yes
Sinus problems	no	yes
Nose bleeds	no	yes
Bleeding gums	no	yes
Sore throat or voice change	no	yes

Genitourinary

Symptom		
Frequent urination	no	yes
Burning or painful urination	no	yes
Blood in urine	no	yes
Sexual difficulty	no	yes
Irregular periods	no	yes

Respiratory

Symptom		
Frequent coughing	no	yes
Spitting up blood	no	yes
Shortness of breath	no	yes
Asthma or wheezing	no	yes

Gastrointestinal

Symptom		
Loss of appetite	no	yes
Constipation	no	yes
Nausea or vomiting	no	yes
Frequent diarrhea	no	yes
Blood in stool	no	yes
Stomach pain	no	yes

Musculoskeletal

Symptom		
Joint pain	no	yes
Joint stiffness or swelling	no	yes
Weakness of muscles/joints	no	yes
Muscle pain or cramps	no	yes
Back pain	no	yes
Difficulty in walking	no	yes

Skin and breasts

Symptom		
Rash or itching	no	yes
Change in skin color	no	yes
Varicose veins	no	yes
Breast pain	no	yes

Neurological

Symptom		
Frequent or recurrent headaches	no	yes
Lightheaded or dizzy	no	yes
Convulsions or tingling sensations	no	yes
Tremors	no	yes
Strokes / TIA	no	yes
Head injury	no	yes

Psychiatric

Symptom		
Memory loss or confusion	no	yes
Nervousness / anxiety	no	yes
Depression	no	yes
Sleep problems	no	yes
Snoring	no	yes

Endocrine

Symptom		
Glandular or hormone problem	no	yes
Thyroid disease	no	yes
Diabetes	no	yes
Excessive thirst or urination	no	yes
Heat or cold intolerance	no	yes

Hematologic / Lymphatic

Symptom		
Slow to heal after cuts	no	yes
Easily bruise or bleed	no	yes
Anemia	no	yes
Phlebitis	no	yes
Transfusion	no	yes
Swollen glands	no	yes

Any other problems not yet identified? Please note

Dr. Singh AHS – FOLLOW-UP VISIT PATIENT FORM

(To be completed if you have not been seen in over 3 months or were recently hospitalized)

Name ______________________________ DOB ______________________________

Email ______________________________ Family Dr. ______________________________

Any hospitalizations, surgery, or other major illness since last visit? ☐ **No Changes**

1. ____

2. ____

3. ____

Any recent heart tests? (Outside our office)

☐ Echo (Cardiac ultrasound) ☐ Stress Test

☐ Nuclear Stress Test ☐ Heart Cath

☐ ______________________________

Current Medication List ☐ **No Changes**

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

Current Allergy List ☐ **No Changes**

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

Do you have any specific questions for the doctor on this visit?

1. ____

2. ____

3. ____

Date: ______________________________ Signature ______________________________