SOUTH JERSEY RADIOLOGY ASSOCIATES, P.A.
*Leading The Way in Diagnostic Imaging*
100 Carnie Boulevard • Suite A-1
Voorhees, New Jersey 08043
Phone: (856) 489-5163 • Fax: (856) 489-1726

# Review of Systems VASCULAR CARE CENTER

Please read each question and circle the answer which applies.

**CONSTITUTIONAL**

| | | |
|---|---|---|
| Good general health lately | yes | no |
| Recent weight change | yes | no |
| Fever | yes | no |
| Fatigue | yes | no |
| Pain | yes | no |

**EYES**

| | | |
|---|---|---|
| Blurred/double vision | yes | no |
| Poor vision, contacts, glasses | yes | no |
| History of eye disease | yes | no |

**EARS/NOSE/MOUTH/THROAT**

| | | |
|---|---|---|
| Ringing in the ears | yes | no |
| Change in hearing | yes | no |
| Deafness/hearing aid | yes | no |
| Sore throat | yes | no |
| Trouble swallowing | yes | no |

**CARDIOVASCULAR**

| | | |
|---|---|---|
| History of rheumatic fever | yes | no |
| History of heart attack | yes | no |
| History of stroke | yes | no |
| History of CHF or chest pain | yes | no |
| Palpitations | yes | no |
| History of hypertension | yes | no |
| History of phlebitis/blood clots | yes | no |
| Do you use oxygen at home | yes | no? |
| Do you have a pacemaker | yes | no |
| Swelling of legs/ankles | yes | no |
| Varicose veins | yes | no |

**RESPIRATORY**

| | | |
|---|---|---|
| Frequent colds | yes | no |
| Difficulty breathing, shortness of breath | yes | no |
| Cough | yes | no |
| Asthma | yes | no |
| Hay fever | yes | no |
| Chronic Obstructive Pulmonary Disease | yes | no |
| Tuberculosis (TB) | yes | no |

**GASTROINTESTINAL**

| | | |
|---|---|---|
| Heartburn | yes | no |
| Vomiting | yes | no |
| Constipation | yes | no |
| Diarrhea | yes | no |
| Blood in stool | yes | no |
| Peptic ulcer | yes | no |
| Abdominal pain | yes | no |

**INTEGUMENTARY (SKIN)**

| | | |
|---|---|---|
| Rash | yes | no |
| History of masses | yes | no |
| Birthmarks, warts, lumps, nodules | yes | no |
| Slow to heal after cuts | yes | no |
| Bleeding/bruising tendency | yes | no |
| Hair growth | yes | no |
| Gangrene | yes | no |

**MUSCULOSKELETAL**

| | | |
|---|---|---|
| Leg pain (rest or walking) | yes | no |
| Back pain | yes | no |
| Joint pain or swelling | yes | no |

**ENDOCRINE**

| | | |
|---|---|---|
| Excessive thirst | yes | no |
| Thyroid disease | yes | no |
| Heat/cold intolerance | yes | no |
| Diabetes | yes | no |
| Do you monitor your blood sugar | | |
| Controlled? | yes | no |
| Medication? | yes | no |
| Do you monitor your blood sugar? | yes | no |

**PSYCHIATRIC**

| | | |
|---|---|---|
| Depression/anxiety | yes | no |
| Change in memory | yes | no |

**IMMUNOLOGIC**

| | | |
|---|---|---|
| Rheumatoid arthritis | yes | no |
| Lupus | yes | no |
| Sickle cell disease | yes | no |
| Scleroderma | yes | no |
| Vasculitis | yes | no |
| HIV/AIDS | yes | no |

**NEUROLOGICAL**

| | | |
|---|---|---|
| Spinal cord injury | yes | no |
| Seizures | yes | no |
| Tremors | yes | no |
| Numbness/tingling | yes | no |
| Difficulty with balance | yes | no |
| Paralysis | yes | no |
| Aphasia | yes | no |
| Changes in sensation | yes | no |

Describe-____________________________

**HEMATOLOGIC/LYMPHATIC**

| | | |
|---|---|---|
| Blood borne disease | yes | no |
| Anemia | yes | no |
| Blood abnormalities | yes | no |

**GENITOURINARY**

| | | |
|---|---|---|
| Renal disease/dialysis | yes | no |
| Difficulty with urination | yes | no |
| Frequent/burning urination | yes | no |
| Incontinence | yes | no |
| Blood in urine | yes | no |
| Menses/vaginal bleeding/pain | yes | no |
| Testicular/prostate problems | yes | no |
| History of STD's | yes | no |

**OTHER**

| | | |
|---|---|---|
| History of cancer | yes | no |

Type of Cancer-__________________________

| | | |
|---|---|---|
| Chemotherapy | yes | no |
| Radiation treatments | yes | no |
| Evidence of abuse or neglect | yes | no |

## ADDITIONAL INFORMATION

______________________________________

______________________________________

______________________________________

**FOR OFFICE USE ONLY**

Reviewed and concur with above History & ROS?

Yes or No

Exam Dictated Yes or No

NURSE INITIALS __________________

PHYSICIAN SIGNATURE _____________________

DATE_________________