MEMORIAL KATY
CARDIOLOGY ASSOCIATES

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Review of Symptoms

Name: _____ **DOB:** _____

What is the main reason for your Visit? *(example: check-up)* _____

_____

Review of Recent Symptoms: *Circle all that apply or circle **"none"***

Respiratory:
- None
- Shortness of breath with exertion
- Shortness of breath lying flat
- Shortness of breath waking at night
- Sleep disturbances due to breathing
- Cough
- Coughing blood

Constitutional:
- None
- Fevers
- Weight gain
- Weight loss

Endocrine:
- None
- Cold intolerance
- Fatigue

Musculoskeletal:
- None
- Joint pain (arthritis)
- Muscle aches

Psychiatric:
- None
- Depression
- Anxiety

Cardiovascular:
- None
- Chest pain while resting
- Chest pain with exertion
- Racing or skipping heart beats (palpitations)
- "Passing out" or fainting
- Swelling of legs
- Leg cramps with exertion

Gastrointestinal:
- None
- Nausea / Vomiting
- Heartburn
- Abdominal pain
- Dark tarry or black stools

Genitourinary:
- None
- Blood in urine
- Lack of sexual function (impotence)

Hematology/Lymphatic:
- None
- Abnormal bruising

Do you currently Smoke? **No** **Yes** Packs per day? _____

Please update Allergy list: _____

_____

Please update Pharmacy: _____

_____

For office Use Only: Was an ECG performed? (Circle one) Yes No

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