VascularInstitute
NavicentHealth

Patient Name: _____

Please fill in the appropriate circle as they relate to your health

Review of Systems

Dizziness	O Yes O No
Syncope	O Yes O No
Weakness on one side	O Yes O No
Generalized weakness	O Yes O No
Blood in sputum	O Yes O No
Blood in emesis	O Yes O No
Passing blood from rectum	O Yes O No
Chest pain	O Yes O No
Shortness of breath	O Yes O No
Awakening breathless	O Yes O No
Sleeping on multiple pillows	O Yes O No
Cough	O Yes O No
Sweating at night	O Yes O No
Swelling in feet	O Yes O No
Changes in weight	O Yes O No
Changes in appetite	O Yes O No
Leg pain at night	O Yes O No
Leg pain while walking	O Yes O No
Discoloration of feet	O Yes O No
Discoloration of toes	O Yes O No
Skin rash	O Yes O No
Skin discoloration	O Yes O No
Changes in vision	O Yes O No
Changes in speech	O Yes O No
Constipation	O Yes O No
Diarrhea	O Yes O No
Vomiting	O Yes O No
Heartburn	O Yes O No

Social History

Smoking
Status:

- O Current Smoker
- O Current every day smoker
- O Current Someday smoker
- O Former Smoker
- O Never Smoker
- O Current Status unknown
- O Unknown if ever smoker

Alcohol	O Yes O No
Recreational Drug Use	O Yes O No
Marital Status	O Yes O No
Employment	O Yes O No