

# CASCADE HEART

## NEW PATIENT R.O.S. FORM



PATIENT NAME \_\_\_\_\_

Birth Date \_\_\_\_\_

Please circle the appropriate response to the following symptoms or conditions.

Please elaborate on any positive responses (i.e. frequency, severity, recent changes).

Night sweats	Yes	No	_____
Fevers or chills	Yes	No	_____
Swollen glands	Yes	No	_____
Weight Change	Yes	No	_____
Cancer	Yes	No	_____
Appetite Change	Yes	No	_____
Rashes	Yes	No	_____
Other skin changes	Yes	No	_____
Bleeding or Bruising	Yes	No	_____
Anemia	Yes	No	_____
Visual problems	Yes	No	_____
Hearing problems	Yes	No	_____
Sinus problems	Yes	No	_____
Seasonal allergies	Yes	No	_____
Swallowing problems	Yes	No	_____
Headaches	Yes	No	_____
Breathing Problems	Yes	No	_____
Cough (Blood?)	Yes	No	_____
Chest discomfort	Yes	No	_____
Heartburn	Yes	No	_____
Hiatal Hernia	Yes	No	_____
Bowel habit change	Yes	No	_____
Black or bloody stool	Yes	No	_____
Diarrhea	Yes	No	_____
Urine problems	Yes	No	_____
Limb numbness	Yes	No	_____
Joint/Back pain	Yes	No	_____
Calf pain with walking	Yes	No	_____
Swollen ankles	Yes	No	_____
Speech difficulties	Yes	No	_____
Anxiety	Yes	No	_____
Depression	Yes	No	_____

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_