



NEW PATIENT R.O.S FORM

PLEASE CIRCLE THE APPROPRIATE RESPONSE TO THE FOLLOWING SYMPTOMS

PATIENT NAME: _____

BIRTH DATE: _____

General

Weight change Yes No
 Chills Yes No
 Fatigue Yes No
 Fever Yes No
 Night sweats Yes No
 Sleep disturbance Yes No

Skin

Bruising Yes No
 Rash Yes No
 Skin changes Yes No

HEENT

Headache Yes No
 Visual problems Yes No
 Hearing problems Yes No
 Seasonal allergies Yes No
 Sinus problems Yes No

Neck

Swollen glands Yes No

Respiratory

Cough Yes No
 Snoring Yes No
 Breathing problems Yes No
 Sputum production Yes No
 Bloody sputum Yes No

Cardiovascular

Chest discomfort Yes No
 Fainting/Blacking out Yes No
 Irregular heart beat Yes No
 Swelling of Extremities Yes No
 Difficulty breathing lying down Yes No

Gastrointestinal

Black, tarry stool Yes No
 Bloody stool Yes No
 Change in bowel habits Yes No
 Difficulty swallowing Yes No
 Heartburn Yes No
 Nausea Yes No
 Vomiting Yes No

Genitourinary

Blood in urine Yes No
 Change in bladder habits Yes No
 Impotence Yes No

Musculoskeletal

Calf pain with walking Yes No
 Joint pain Yes No
 Muscle pain Yes No
 Muscle weakness Yes No

Neurological

Difficulty speaking Yes No
 Numbness in limbs Yes No
 Lightheadedness Yes No
 Spinning sensation Yes No

Psychiatric

Anxiety Yes No
 Depression Yes No

Endocrine

Appetite change Yes No
 Thyroid problems Yes No

Hematology

Abnormal bleeding Yes No
 Anemia Yes No

