Patient Name: ____DOB:__________________

SS#___________________________________

Instructions: Please __fill in the bubble completely__ next to each item which applies to you.

******* Please DO NOT use a check mark or "X" to mark the bubbles ******* ***(ROS)***

General/Constitutional

Chills O Yes

Fatigue O Yes

Fever O Yes

Sleep disturbance O Yes

Allergy/Immunology

Hives O Yes

Rash O Yes

Endocrine

Cold intolerance O Yes

Frequent urination O Yes

Weight loss O Yes

Respiratory

Chest pain O Yes

Short of breath at rest O Yes

Wheezing O Yes

Sputum production O Yes

Cardiovascular

Chest pain at rest O Yes

Difficulty laying flat O Yes

Dyspnea on exertion O Yes

Claudication O Yes

Gastrointestinal

Nausea O Yes

Heartburn O Yes

Difficulty swallowing O Yes

Hematology

Easy bruising O Yes

Recent transfusion O Yes

Prolonged bleeding O Yes

Swollen glands O Yes

Genitourinary

Blood in urine O Yes

Frequent urination O Yes

Painful urination O Yes

Peripheral Vascular

Absent pulses in feet O Yes

Cold extremities O Yes

Pain/cramping in legs after exertion O Yes

Ulceration of feet O Yes

Skin

Scaly lesions of skin/scalp O Yes

Eczema O Yes

Skin oozing O Yes

Neurologic

Seizures O Yes

Tremor O Yes

Gait abnormality O Yes

Fainting O Yes

Psychiatric

Auditory/visual hallucinations O Yes

Difficulty sleeping O Yes

Suicidal thoughts O Yes

Mental or Physical abuse O Yes