ROS TYPE 1

EPILEPSY QUESTIONNAIRE
DEPARTMENT OF NEUROLOGY, BAYLOR COLLEGE OF MEDICINE

DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING SYMPTOMS/COMPLAINTS?

	NO	YES	DESCRIBE (If "yes")
Weight gain		✓	TOO much
Weight loss	✓		
Easy fatigue		✓	* After A Seizure
Change in sleep pattern		✓	Sleep on couch
Stomach pain		✓	bowel movements
Loss of appetite		✓	At times
Nausea, vomiting		✓	
Heartburn		✓	GERD
Diarrhea		✓	
Constipation		✓	Back & forth
Change in color of stool	✓		
Chest Pain	✓		
Palpitations (funny heart beat)		✓	
Night sweats		✓	
Cough		✓	
Shortness of breath		✓	
Wheezing	✓		
Chest pain with deep breathing	✓		
Pain with urination	✓		
Frequent urination	✓		
Urinary incontinence	✓		
Blood in urine	✓		
Skin rash	✓		
Joint pains		✓	
Muscle cramps		✓	
Weakness		✓	~~tired~~ tired
Numbness		✓	HANDS & ARMS
Double vision		✓	
Difficulty swallowing		✓	
Slurred speech		✓	
Dizziness		✓	
Headaches		✓	
Poor control of bladder	✓		
Tremors / hand shaking		✓	Drops objects
Loss of muscle bulk	✓		
Fainting spells	✓		
Poor condition		✓	Since having Seizure
Droopy face or eye	✓		
Neck / back pain		✓	After seizures
Change in vision		✓	
Change in hearing	✓		
Stability/Mobility		✓	Poor balance
Memory		✓	Difficult w/ short t

ROS TYPE 2

Please review the list of symptoms and check "yes" if you have any of these symptoms currently. Please check "no" if you have not experienced any of the symptoms.

Constitutional (1)

- ☐ Yes ☒ No Fever / Chills / Sweats
- ☐ Yes ☒ No Weight Loss
- ☒ Yes ☐ No Tiredness / Fatigue
- ☐ Yes ☒ No Poor Appetite

Eyes (2)

- ☐ Yes ☐ No Reduced Vision or Blurriness
- ☐ Yes ☐ No Double Vision
- ☒ Yes ☐ No Droopy Eye Lids
- ☐ Yes ☒ No Cataracts
- ☐ Yes ☒ No Glaucoma

Ears/Mouth/Nose/Throat (3)

- ☐ Yes ☒ No Hearing Loss
- ☐ Yes ☒ No Ringing in the Ears
- ☐ Yes ☒ No Vertigo
- ☐ Yes ☒ No Hoarseness
- ☐ Yes ☒ No Sinus Pain
- ☐ Yes ☒ No Swallowing Problem

Cardiovascular (4)

- ☐ Yes ☒ No Chest Pain/Angina
- ☐ Yes ☒ No Palpitations
- ☒ Yes ☐ No Shortness of Breath Lying Flat
- ☐ Yes ☒ No Pain in the Legs with Walking
- ☐ Yes ☒ No Phlebitis
- ☐ Yes ☒ No Heart Attack
- ☐ Yes ☒ No High Blood Pressure
- ☒ Yes ☐ No High Cholesterol/Lipids

Respiratory (5)

- ☐ Yes ☒ No Cough
- ☐ Yes ☒ No Phlegm
- ☐ Yes ☒ No Coughing up Blood
- ☐ Yes ☒ No Wheezing/Asthma

Gastrointestinal (6)

- ☒ Yes ☐ No Abdominal Pain
- ☒ Yes ☐ No Nausea and/or Vomiting
- ☐ Yes ☒ No Vomiting up Blood
- ☒ Yes ☐ No Change in Bowel Movements
- ☒ Yes ☐ No Diarrhea
- ☒ Yes ☐ No Constipation
- ☐ Yes ☒ No Blood in Stool

Genitourinary (7)

- ☐ Yes ☒ No Pain with Urination
- ☐ Yes ☒ No Excessive Urination
- ☐ Yes ☒ No Incontinence
- ☐ Yes ☒ No Blood in Urine
- ☐ Yes ☒ No Sexual Problems
- ☐ Yes ☒ No Prostate Problems

Musculoskeletal (8)

- ☒ Yes ☐ No Neck or Back Pain
- ☒ Yes ☐ No Muscle Pain
- ☒ Yes ☐ No Pain/Redness/Swelling of a Joint

Skin (9)

- ☒ Yes ☐ No Rash
- ☐ Yes ☒ No Change in Sweating

- ☐ Yes ☒ No Burns

Neurologic (10)

- ☒ Yes ☐ No Headache
- ☒ Yes ☐ No Numbness or Tingling
- ☒ Yes ☐ No Muscle Weakness
- ☒ Yes ☐ No Loss of Consciousness (fainting)
- ☒ Yes ☐ No Memory or Thinking Problems
- ☒ Yes ☐ No Trouble with Walking or Balance
- ☐ Yes ☒ No Stroke
- ☒ Yes ☐ No Seizure

Psychiatric (11)

- ☐ Yes ☐ No Psychological or Psychiatric Care
- ☐ Yes ☐ No Depression
- ☐ Yes ☐ No Hallucinations
- ☐ Yes ☐ No Anxiety
- ☐ Yes ☒ No Suicidal Thoughts

Endocrine (12)

- ☐ Yes ☒ No Hot Cold Intolerance
- ☐ Yes ☒ No Thyroid Problems
- ☐ Yes ☒ No Diabetes or Sugar Problems

Hematologic/Lymphatic (13)

- ☐ Yes ☒ No Anemia
- ☐ Yes ☐ No Easy Bruising
- ☐ Yes ☐ No Enlarged Lymph Nodes

Allergic/Immunologic (14)

- ☐ Yes ☒ No Severe Allergic Reaction
- ☐ Yes ☒ No Frequent Infections

Do you have difficulties with any of the following activities? (Please CHECK as these apply)

☐ Yes	☒ No	Bathing	☑ Yes	☐ No	Driving	☑ Yes	☐ No	Cleaning
☐ Yes	☒ No	Toileting	☑ Yes	☐ No	Dressing	☐ Yes	☐ No	Shopping
☐ Yes	☒ No	Eating	☐ Yes	☒ No	Taking medications	☐ Yes	☐ No	Using the Phone
☑ Yes	☐ No	Paying Bills	☑ Yes	☐ No	Cooking	☑ Yes	☐ No	Traveling

Have you used the following services in the past three months? (Please CHECK as these apply)

☐ Yes	☒ No	Visiting Nurse	☐ Yes	☒ No	Home Health Services	☐ Yes	☒ No	Day Program
☐ Yes	☒ No	Physical Therapy	☐ Yes	☒ No	Meal Program	☐ Yes	☒ No	Mental Health Services
☐ Yes	☒ No	Occupational Therapy	☐ Yes	☒ No	Speech Therapy	☐ Yes	☒ No	Other

PLEASE BRING COMPLETED FORM TO YOUR APPOINTMENT
Please bring Insurance cards (Authorization if Needed)
And available x-rays, MRI scans and previous medical records
THANK YOU FOR COMPLETING THIS FORM

Reviewed by Dr.:_____ Date Reviewed: _____

ROS TYPE 3

REVIEW OF SYSTEMS

Please check yes or no for the following problems & conditions:	**Yes**	**No**
General: Nausea/Vomiting?		X
Fever/Chills?		X
Weight loss or gain? Please specify: 10-15 lbs in 12 months	X	X
Skin: Rashes?		X
Skin Color Changes		X
Heent: Recent changes in vision?		X
Persistent Cough?		X
Cardiac: Chest Pain?		X
Angioplasty or stents for the heart?		X
Recent EKG or Stress Test?	X	
Respiratory: Shortness of breath?		X
Can you walk up a flight of stairs without stopping?	X	
Vascular: Circulation problems in the legs?		X
Pain in your legs when you walk?		X
Angioplasty or bypass surgery for the legs?		X
Foot wounds that would not heal?		X
Leg swelling?		X
Varicose veins?		X
Neurologic: Weakness or numbness on one side of the body? small fingers (both)	X	
Dizziness/Fainting Spells?		X
Loss of vision?		X

GI: Abdominal Pain?		X
Acid Reflux?		X
Stomach ulcers?		X
Stomach pain with eating?		X
Change in bowel movements? ~~SE~~ loose & running stool	X	
Musculoskeletal: Back Pain?		X
Painful Joints?		X
Heme/Onc: Bleeding/Disorder		X

The above ROS were reviewed with patient. **Physician Initials:** _____

MEDICATIONS

Please list the medications you take, the dose, and how often you take them.

See list

ROS TYPE 4

REVIEW OF SYSTEMS by SYSTEMS – Page 4

Do you currently have any of these symptoms?

Head and Neck	YES	NO
Swelling		✓
Masses		✓
Hoarseness		✓
Difficulty swallowing		✓
Neck pain		✓
Neck spasm		✓

Neuromuscular	YES	NO
Cramps		✓
Weakness in limbs		✓
Loss of control of arms of legs		✓
Poor coordination		✓
Numbness		✓
Tingling		✓
Loss of sensation		✓
Loss of muscle		✓
Poor vision		✓
Blurry vision		✓
Double vision		✓
Loss of hearing		✓
Ringing in ears		✓
Numbness in face		✓
Decreased ability to smell		✓
Decreased ability to taste		✓
Droopy face or eye		✓
Hoarseness		✓
Difficulty speaking		✓
Difficulty with speech		✓
Slurred speech		

Cardio-respiratory	YES	NO
Shortness of breath		✓
Chest pain		✓
Chronic cough		✓
Coughing blood		✓
Emphysema		✓
Bronchitis		✓
Palpitations		✓

Do you currently have any of these symptoms?

Gastro-Intestinal	YES	NO
Weight loss	____	✓
Blood in stool	____	✓
Dark colored stool	____	✓
Abdominal Pain	____	✓
Hernia	____	✓
Difficulty swallowing	____	✓
Nausea	____	✓
Vomiting	____	✓
Abdominal swelling	____	✓
Diarrhea	____	✓
Constipation	____	✓
Abdominal mass	____	✓

Genito-Urinary	YES	NO
Burning with urination	____	✓
Dark or discolored urine	____	✓
Difficulty urinating	____	✓
Poor control of bladder	____	✓
Any type of sexual dysfunction	____	✓
Excessive urination	____	✓
Excessive thirst	____	✓

Endocrine	YES	NO
Poor appetite	____	✓
Cold intolerance	____	✓
Dry skin	____	✓
Excessive thirst	____	✓
Hair loss	____	✓
Extreme nervousness	____	✓
Extreme weight gain	____	✓
Extreme weight loss	____	✓

Psychiatric

Psychiatric Issues/Problems (please list): _____

_____

_____

_____

ROS TYPE 5

REVIEW OF SYSTEMS by SYSTEMS – Page 4

Do you currently have any of these symptoms?

Head and Neck	YES	NO
Swelling		✓
Masses		✓
Hoarseness		✓
Difficulty swallowing		✓
Neck pain		✓
Neck spasm		✓

Neuromuscular	YES	NO
Cramps		✓
Weakness in limbs		✓
Loss of control of arms of legs		✓
Poor coordination		✓
Numbness	✓	
Tingling	✓	
Loss of sensation		✓
Loss of muscle		✓
Poor vision		✓
Blurry vision		✓
Double vision		✓
Loss of hearing		✓
Ringing in ears		✓
Numbness in face		✓
Decreased ability to smell		✓
Decreased ability to taste		✓
Droopy face or eye		✓
Hoarseness		✓
Difficulty speaking		✓
Difficulty with speech		✓
Slurred speech		✓
Seizures	✓	
Headaches		✓

Cardio-respiratory	YES	NO
Shortness of breath		✓
Chest pain		✓
Chronic cough		✓
Coughing blood		✓
Emphysema		✓
Bronchitis		✓
Palpitations		✓
Asthma		✓

REVIEW OF SYSTEMS by SYSTEMS cont. – Page 5

Do you currently have any of these symptoms?

Gastro-Intestinal	**YES**	**NO**
Weight loss	____	✓
Blood in stool	____	✓
Dark colored stool	____	✓
Abdominal Pain	____	✓
Hernia	____	✓
Difficulty swallowing	____	✓
Nausea	____	✓
Vomiting	____	✓
Abdominal swelling	____	✓
Diarrhea	____	✓
Constipation	____	✓
Abdominal mass	____	✓

Genito-Urinary	**YES**	**NO**
Burning with urination	____	✓
Dark or discolored urine	____	✓
Difficulty urinating	____	✓
Poor control of bladder	____	✓
Any type of sexual dysfunction	____	✓
Excessive urination	____	✓
Excessive thirst	____	✓

Endocrine	**YES**	**NO**
Poor appetite	____	✓
Cold intolerance	____	✓
Dry skin	____	✓
Excessive thirst	____	✓
Hair loss	____	✓
Extreme nervousness	____	✓
Extreme weight gain	____	✓
Extreme weight loss	____	✓