ENT and ALLERGY SPECIALISTS

REVIEW OF SYSTEMS

Ear, Nose, & Throat
Sinus and allergy disorders
Sinus surgery
Sublingual immunotherapy
Sleep & snoring disorders
Radiofrequency & laser treatments
Head & neck surgery
Skin cancer
Speech & swallowing disorders
Ear disorders & surgery
Voice disorders
Balance disorders
Thyroid surgery
Pediatric ear, nose, & throat disorders

Audiology
Hearing evaluations
Hearing aids
Balance testing & treatment
Newborn hearing screening

Facial Plastic/Cosmetic
Facial plastic surgery
Non-invasive facial treatments
Botox/Restylane
Laser skin resurfacing
Hair removal
Skin care
Laser vein therapy

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Patient Name: _____ **Date**:_____

Referring Physician: _____**DOB**:_____

Review of Systems :

1) ***Please check all problems that you have OR Please check "None"***

Constitutional: □*None*
□fevers (how high? ____)□chills □loss of appetite □hair loss
□ Unexplained weight (circle) GAIN/LOSS;
if yes-when? _____ how much?_____

EYES: □*None*
□pain □vision changes □double vision □itching

ENT: □*None*
Ear: □pain □discharge □lump □hearing loss □tinnitus **(circle one)** left/right/both
Nose: □pain □discharge □lump □loss of smell □stuffy **(circle one)** left/right/both
Mouth: □pain □discharge □lump □loss of taste □cavities □dentures
Throat: □pain □lump □thick mucus □tickle □cough □trouble swallowing □hoarse voic

Cardiovascular: □*None*
□chest pain □history of heart attack □shortness of breath □leg cramp
□irregular heart beat □history of heart disease/coronary artery diseas

Respiratory: □*None*
□cough □sputum □wheezing □asthma □COPD □pneumonia
□tuberculosis

GI: □*None*
□nausea □diarrhea □constipation □blood in stool □hepatitis □vomitin

Urinary: □*None*
□kidney stones □bladder infections □frequent urination
□difficult urination □bloody urine □bladder cancer □painful urinatio

Neuro: □*None*
□history of stroke □headache □weakness □seizures □vision changes
□double vision □cataracts

Musculoskeletal: □*None*
□joint pain □joint swelling □muscle pain □swelling □stiffness

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Skin: □*None*
□birthmark (where?_____) □rash(where?_____)
□lesions (where?_____)

Psychiatric: □*None*
□anxiety □depression □mood swings □other_____

Endocrine: □*None*
□always cold/hot □hot flashes □irregular periods □frequent sweating

Hematologic: □*None*
□easy bruising □history of anemia □lethargy

Allergic/Immuno: □*None*
□sneezing □itching □runny nose □frequent colds/infections
□history of AIDS

2) ***Please sign here:***
The responses above are accurate to the best of my knowledge:

_____ _____
(signature if over 18) (date)

If you are not the patient

_____ _____
(**please print your *name***) (***relationship to the patient***)

PLEASE DO NOT WRITE BELOW THIS LINE

DATE UPDATED: _____ **REVIEWED BY**: _____

□ BJB □ LVC □ PBS □ JEG □ SJT □ CFA □ LHB □ SEP □ LRP □ RRM

10/8/2011

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