

ADVANCED EAR, NOSE, & THROAT SPECIALISTS

PATIENT REVIEW OF SYSTEMS

Please check all the symptoms you are CURRENTLY experiencing:

EYES	<input type="checkbox"/> Blurred vision	<input type="checkbox"/> Painful Eyes	<input type="checkbox"/> Sensitivity to light
	<input type="checkbox"/> Itchy, watery eyes	<input type="checkbox"/> Other: _____	
EARS, NOSE, THROAT AND MOUTH	<input type="checkbox"/> Runny nose	<input type="checkbox"/> Blocked nose	<input type="checkbox"/> Post nasal drip
	<input type="checkbox"/> Ringing in the ears	<input type="checkbox"/> Painful swallowing	<input type="checkbox"/> Pressure/fullness in ears
	<input type="checkbox"/> Facial pain/pressure	<input type="checkbox"/> Difficulty swallowing	<input type="checkbox"/> Hoarseness/Change of voice
	<input type="checkbox"/> Pain in _____	<input type="checkbox"/> Lump in neck	<input type="checkbox"/> Other: _____
CARDIOVASCULAR (HEART)	<input type="checkbox"/> Palpitations/ Fluttering of heart		<input type="checkbox"/> Pain in chest
	<input type="checkbox"/> Shortness of breath while exercising		<input type="checkbox"/> Other: _____
RESPIRATORY (LUNGS)	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Cough	<input type="checkbox"/> Shortness of breath
	<input type="checkbox"/> Blood from throat	<input type="checkbox"/> Other: _____	
GASTROINTESTINAL (STOMACH)	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Hiatal hernia	<input type="checkbox"/> Abdominal pain
	<input type="checkbox"/> Constipation	<input type="checkbox"/> Nausea/vomiting	<input type="checkbox"/> Other: _____
GENITOURINARY	<input type="checkbox"/> Pain when urinating	<input type="checkbox"/> Urination at Night	<input type="checkbox"/> Pregnancy
	<input type="checkbox"/> Hesitation when urinating		<input type="checkbox"/> Other: _____
MUSCULOSKELETAL	<input type="checkbox"/> Soreness	<input type="checkbox"/> Weakness	<input type="checkbox"/> Cramping
	<input type="checkbox"/> Other: _____		
INTEGUMENTARY (SKIN)	<input type="checkbox"/> Itchy skin	<input type="checkbox"/> Lesions on Skin	<input type="checkbox"/> Bleeding
	<input type="checkbox"/> Dry skin	<input type="checkbox"/> Other: _____	
NEUROLOGICAL (NERVES)	<input type="checkbox"/> Headaches	<input type="checkbox"/> Ringing in ears	<input type="checkbox"/> Dizziness/ Vertigo
	<input type="checkbox"/> Abnormal movements	<input type="checkbox"/> Imbalance	<input type="checkbox"/> Other: _____
PSYCHIATRIC	<input type="checkbox"/> Mood Swings	<input type="checkbox"/> Situational Stress	<input type="checkbox"/> Depression
ENDOCRINE	<input type="checkbox"/> Hot Flashes	<input type="checkbox"/> Hair loss/ growth	<input type="checkbox"/> Heat/cold sensitivity
	<input type="checkbox"/> Weight gain/loss	<input type="checkbox"/> Other: _____	
HEMATOLOGIC/ LYMPH NODES	<input type="checkbox"/> Bleeding easily	<input type="checkbox"/> Night sweats	<input type="checkbox"/> Swollen lymph nodes
	<input type="checkbox"/> Other: _____		Location: _____
ANESTHESIA	<input type="checkbox"/> NEVER had anesthesia	<input type="checkbox"/> Nausea/Vomiting	<input type="checkbox"/> NO history of anesthesia reactions
	<input type="checkbox"/> Chipped/loose teeth	<input type="checkbox"/> Difficult airway	<input type="checkbox"/> Malignant hyperthermia

PATIENT OR PARENT/GUARDIAN

DATE