

## North Valley Ear, Nose & Throat REVIEW OF SYSTEMS

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Please check (✓) "yes" or "no" to each problem on the list below:

<p><b>GENERAL</b></p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes Fever</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes Weight Change</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes Fatigue</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes Appetite</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes NT Sweats</p> <p><b>EYES</b></p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes Visual Loss</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes Glaucoma</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes Cataracts</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes Itchy Eyes</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes Tearing</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes Blurred Vision</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes Double Vision</p> <p><b>EARS</b></p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes Vertigo</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes Dizziness</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes Ringing Noises</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes Hearing Loss</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes Hearing Aid</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes Infections</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes Trauma</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes Noise Exposure</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes Ear Ache</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes Drainage</p> <p><b>NOSE</b></p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes Discharge</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes Post Nasal Drip</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes Stuffy Nose</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes Bleeding</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes Sneezing</p> <p><b>MOUTH</b></p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes Lumps</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes Dental Problems</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes Tonsillitis</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes Mouth Sores</p>	<p><b>THROAT</b></p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes Hoarseness</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes Voice Change</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes Problem Swallowing</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes Pain</p> <p><b>NECK</b></p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes Pain</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes Lumps</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes Thyroid Nodule</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes Swollen Glands</p> <p><b>SKIN</b></p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes Skin Growths</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes Rash</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes Itching</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes Skin/Hair/Nails Change</p> <p><b>LUNGS</b></p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes Wheezing</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes Coughing up Blood</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes Chronic Cough</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes Shortness of Breath</p> <p><b>SLEEPING</b></p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes Snoring</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes Apnea</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes Insomnia</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes Daytime Tiredness</p> <p><b>HEART</b></p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes Chest Pain</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes Angina</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes Swelling of Hands/Feet</p> <p><b>GASTROINTESTINAL</b></p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes Heartburn</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes Nausea</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes Vomiting</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes Diarrhea</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes Abdominal Pain</p>	<p><b>GENITOURINARY</b></p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes Urination Problems</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes Menopause</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes Pregnant</p> <p><b>MUSCLE JOINTS</b></p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes Muscle Pain</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes Back Pain</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes Joint Pain</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes Arthritis</p> <p><b>NEUROLOGICAL</b></p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes Headaches</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes Migraines</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes Fainting</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes Numbness</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes Weakness</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes Slurred Speech</p> <p><b>PSYCHIATRIC</b></p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes Nervousness</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes Anxiety</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes Depression</p> <p><b>ENDOCRINE</b></p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes Excessive Thirst or Urination</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes Cold/Heat Intolerant</p> <p><b>HEMATOLOGIC</b></p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes Slow to heal after cuts</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes Easy Bruising/Bleeding</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes Immunocompromised</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes Status</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes Transfusions</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes Anemia</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes Blood Clots</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes HIV</p> <p><b>OTHER</b></p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes Previous Anesthesia Problem</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes Other _____</p>
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Physician Reviewed By:

Initials \_\_\_\_\_

Date \_\_\_\_\_