

ENT Review of Systems Update

Name:	Date of Birth:
Date:	Patient's Preferred Name:

Please assist us in keeping your medical record current by filling out this form. Check yes or no next to each item. If an entire category/system does not apply, check *none* next to that category.

Head/Eyes	None	<input type="checkbox"/>
	Yes No	
Visual Changes	<input type="checkbox"/>	<input type="checkbox"/>
Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>

Musculoskeletal	None	<input type="checkbox"/>
	Yes No	
Hand/Foot Swelling	<input type="checkbox"/>	<input type="checkbox"/>
Back or neck problems	<input type="checkbox"/>	<input type="checkbox"/>

Psychiatric	None	<input type="checkbox"/>
	Yes No	
Depression	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Mental Disorder	<input type="checkbox"/>	<input type="checkbox"/>

ENT	None	<input type="checkbox"/>
	Yes No	
Sores in mouth or throat	<input type="checkbox"/>	<input type="checkbox"/>
Face or neck lumps	<input type="checkbox"/>	<input type="checkbox"/>
Nose Bleeds	<input type="checkbox"/>	<input type="checkbox"/>
Teeth/Gum Disease	<input type="checkbox"/>	<input type="checkbox"/>

Skin	None	<input type="checkbox"/>
	Yes No	
Bruising	<input type="checkbox"/>	<input type="checkbox"/>
Rashes	<input type="checkbox"/>	<input type="checkbox"/>
Skin Lesions or Abnormalities	<input type="checkbox"/>	<input type="checkbox"/>

Endocrine	None	<input type="checkbox"/>
	Yes No	
Heat or Cold Intolerance	<input type="checkbox"/>	<input type="checkbox"/>
Electrolyte Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Immune Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>

Respiratory	None	<input type="checkbox"/>
	Yes No	
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Cough	<input type="checkbox"/>	<input type="checkbox"/>
T.B.	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Coughing up Blood	<input type="checkbox"/>	<input type="checkbox"/>
Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>

Gastrointestinal	None	<input type="checkbox"/>
	Yes No	
Stomach Pain or Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Weight Gain	<input type="checkbox"/>	<input type="checkbox"/>
Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>
Dysphasia	<input type="checkbox"/>	<input type="checkbox"/>
Nausea	<input type="checkbox"/>	<input type="checkbox"/>
Acid Reflux	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>

Neurological	None	<input type="checkbox"/>
	Yes No	
Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Muscle Weakness	<input type="checkbox"/>	<input type="checkbox"/>
Numbness/Tingling	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness/Instability	<input type="checkbox"/>	<input type="checkbox"/>
Light Headedness	<input type="checkbox"/>	<input type="checkbox"/>
Sleep Disorder	<input type="checkbox"/>	<input type="checkbox"/>

Cardiovascular	None	<input type="checkbox"/>
	Yes No	
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>
Palpitations	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack YR _____	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heart Beat	<input type="checkbox"/>	<input type="checkbox"/>

Blood/Lymph	None	<input type="checkbox"/>
	Yes No	
Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Easy Bleeding	<input type="checkbox"/>	<input type="checkbox"/>
HIV Concerns	<input type="checkbox"/>	<input type="checkbox"/>

Other		<input type="checkbox"/>
	Yes No	
_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>