Associates
OF OTOLARYNGOLOGY, LLC

Review of Systems

New Patient

Full Name: _____Date of Birth: _____Today's Date: _____

Primary Care Doctor: _____ Referring Doctor (if different): _____

1. Constitutional

Weight gain	Y	N
Weight loss	Y	N

2. Eyes

Vision changes	Y	N
Itchy/Redness	Y	N
Swollen eyelids	Y	N
Redness	Y	N

3. Ears, Nose, Throat

Hearing loss	Y	N
Ringing	Y	N
Pressure	Y	N
Nasal Congestion	Y	N
Nose Bleeds	Y	N
Sinus Infections	Y	N
Hoarseness	Y	N
Phlegm	Y	N

4. Heart

Chest pain	Y	N
Palpitations	Y	N
Fainting	Y	N

5. Respiratory

Snoring	Y	N
Cough	Y	N
Wheezing	Y	N

6. Musculoskeletal

Joint pain	Y	N
Muscle pain	Y	N

7. Skin

Hives	Y	N
Eczema	Y	N
Rash	Y	N

8. Gastroenterology

Nausea/vomiting	Y	N
Reflux	Y	N

9. Neurological

Dizziness	Y	N
Headache	Y	N

10. Psychiatric

Depression	Y	N
Anxiety	Y	N

11. Endocrine

Goiter/thyroid problems	Y	N
Fatigue	Y	N

If yes to any questions, please describe:

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