HEAD & NECK SURGICAL GROUP
REVIEW OF SYSTEMS

Patient Name: ______________________________ **Date:** ______________

General/Constitutional	**Yes**	**No**
Change in appetite		
Fatigue		
Fever		
Sleep Disturbance		
Weight gain		
Weight loss		

Allergic / Immunology	**Yes**	**No**
Allergic rhinitis		
Hay fever		
Positive TB test		
Hives		
HIV (+)		
Food allergies		
Other:		

Ear / Nose / Mouth / Throat	**Yes**	**No**
Tinnitus		
Sinusitis		
Nasal polyps		
Altered sense of smell		
Nose bleeds		
Deviated septum		
Mouth sores		
Pain with chewing		
Facial trauma		
Dizziness/Vertigo		
Hearing Loss		
Ear discharge		
Ear pain		
Sore throat		

Do you drink alcohol?	**Yes**	**No**
How much?		

Endocrine	**Yes**	**No**
Thyroid lump / nodule		
Eye protrusion		
Diabetes w/insulin		
Diabetes w/o insulin		
Menstrual disorders		
Cold intolerance		
Excessive sweating		
Excessive thirst		
Frequent urination		
Heat intolerance		

Respiratory	**Yes**	**No**
Chest congestion		
Hoarseness		
Excessive throat clearing		
Spitting up blood		
Asthma		
Chronic Bronchitis		
Emphysema		
Tuberculosis		
Lung Cancer		
Cough		
Wheezing		

Cardiovascular	**Yes**	**No**
High Blood Pressure		
Swelling of the ankles		
Angioplasty		
Coronary artery stents		
Pacemaker		
Chest pain at rest		
Chest pain with exertion		
Palpitations		
Shortness of breath		

Do you smoke?	**Yes**	**No**
How much?		

Genitourinary	**Yes**	**No**
Abdominal pain/swelling		
Blood in urine		
Difficulty on Urination		
Frequent Urination		
Pain in lower back		
Painful urination		

Musculoskeletal	**Yes**	**No**
Back pain		
Arthritis		
Joint stiffness		
Muscle aches		
Painful joints		
Swollen joints		
Muscle weakness		

Skin	**Yes**	**No**
Sores/Growths		
Nail changes		
Itching		
Rash		

Neurological	**Yes**	**No**
Head injury		
Balance difficulty		
Gait abnormality		
Headache		
Memory loss, confusion		
Seizures		
Tingling/Numbness		
Tremor		

Height:

Weight:

All Medications and Dosages **(inc. non-prescription)** None ☐

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All Surgeries / Operations None ☐

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Past and Present Medical Problems

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Chief Complaint - Primary reason for today's visit:

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Medication Allergies None ☐

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Patient Signature ______________________________

Physician Signature ______________________________ **Date** ______________