Patient Name_____Date of Birth_____

Review of Systems

Are you currently, or have you had, problems with:

Constitutional	*Circle One*	
Fever	Yes	No
Weight Loss	Yes	No
Excessive Fatigue	Yes	No
Night Sweats	Yes	No
Eyes		
Wear Glasses---Date of Last Exam:_____	Yes	No
Infections	Yes	No
Injuries	Yes	No
Glaucoma	Yes	No
Cataracts	Yes	No
Sinus Headaches	Yes	No
Ear, Nose, Throat and Mouth		
Wear Hearing Aids---Date of Last Exam:_____	Yes	No
Hearing Loss	Yes	No
Ear Pain	Yes	No
Ear Infections	Yes	No
Ringing In Ears *Circle:* Left Right Both	Yes	No
Balance Disturbance (e.g., Vertigo, Spinning)	Yes	No
Nosebleeds	Yes	No
Nasal Congestion	Yes	No
Nasal Drainage---Amount_____ Color_____	Yes	No
Inability To Smell	Yes	No
Sinus Problems	Yes	No
Sore Throat	Yes	No
Mouth Sores	Yes	No
Cardiovascular		
Chest Pain or Angina--- Date of Last EKG:_____	Yes	No
High Blood Pressure	Yes	No
Irregular Pulse	Yes	No
Heart Murmur	Yes	No
High Cholesterol	Yes	No
Swelling in Feet or Hands	Yes	No
Leg Pain While Walking	Yes	No