

# PATIENT HISTORY QUESTIONNAIRE/REVIEW OF SYSTEMS

NAME \_\_\_\_\_ Date: \_\_\_\_\_

Who referred you? \_\_\_\_\_ Reason \_\_\_\_\_

Symptoms: \_\_\_\_\_

For how long? \_\_\_\_\_

What treatment have you received? \_\_\_\_\_

Patient/Parent or Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Are you currently or do you regularly experience: *(Please check all that apply)*

<b>Constitutional</b>	<input type="checkbox"/> Weight loss	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Fever
<b>Eyes</b>	<input type="checkbox"/> Blurred Vision	<input type="checkbox"/> Double vision	<input type="checkbox"/> Eye pain
<b>Ears, Nose, Throat &amp; Mouth</b>	<input type="checkbox"/> Headaches	<input type="checkbox"/> Vertigo/Dizziness	<input type="checkbox"/> Hearing loss
	<input type="checkbox"/> Ringing in ears	<input type="checkbox"/> Roaring sound in ears	<input type="checkbox"/> Ear fullness
	<input type="checkbox"/> Pressure sensation in ear	<input type="checkbox"/> Itching in ear	<input type="checkbox"/> Ear discharge
	<input type="checkbox"/> Ear pain	<input type="checkbox"/> Nasal pain	<input type="checkbox"/> Decreased sense of smell
	<input type="checkbox"/> Nasal obstruction	<input type="checkbox"/> Sinus pain	<input type="checkbox"/> Nasal congestion
	<input type="checkbox"/> Nose bleeding	<input type="checkbox"/> Nasal discharge	<input type="checkbox"/> Postnasal drip
	<input type="checkbox"/> Purulent nasal discharge	<input type="checkbox"/> Mouth pain	<input type="checkbox"/> Swollen glands
	<input type="checkbox"/> Sore throat	<input type="checkbox"/> Snoring	<input type="checkbox"/> Hoarseness
	<input type="checkbox"/> Change in voice	<input type="checkbox"/> Frequent throat clearing	<input type="checkbox"/> Difficulty swallowing
	<input type="checkbox"/> Neck tenderness	<input type="checkbox"/> Dentures	<input type="checkbox"/> Lump in throat sensation
<b>Cardiovascular</b>	<input type="checkbox"/> Chest pain	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Palpitations
<b>Respiratory (Lungs)</b>	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Cough
	<input type="checkbox"/> Coughing blood		
<b>Gastrointestinal (Stomach)</b>	<input type="checkbox"/> Nausea	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Difficulty swallowing
	<input type="checkbox"/> Painful swallowing	<input type="checkbox"/> Excessive belching	<input type="checkbox"/> Heartburn/Acid reflux
<b>Genitourinary</b>	<input type="checkbox"/> Urgency	<input type="checkbox"/> Frequency	<input type="checkbox"/> Pain when urinating
<b>Integumentary (Skin)</b>	<input type="checkbox"/> New skin lesions	<input type="checkbox"/> Pigmentation changes	<input type="checkbox"/> Changes to existing skin lesions
<b>Neurological (Nerves)</b>	<input type="checkbox"/> Tremors	<input type="checkbox"/> Seizures	<input type="checkbox"/> Loss of balance
	<input type="checkbox"/> Tingling or numbness		
<b>Musculoskeletal</b>	<input type="checkbox"/> Joint pain	<input type="checkbox"/> Joint swelling	<input type="checkbox"/> Muscle pain
<b>Endocrine</b>	<input type="checkbox"/> Cold intolerance	<input type="checkbox"/> Heat intolerance	<input type="checkbox"/> Loss of hair
	<input type="checkbox"/> Weight loss	<input type="checkbox"/> Weight gain	<input type="checkbox"/> Hot flashes
<b>Psychiatric</b>	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Depression	<input type="checkbox"/> Difficulty sleeping
<b>Hematologic/ Lymph Nodes</b>	<input type="checkbox"/> Easy bleeding	<input type="checkbox"/> Easy bruising	<input type="checkbox"/> Lymph node enlargement or tenderness
<b>Allergic/Immunologic</b>	<input type="checkbox"/> Reaction to anesthesia	<input type="checkbox"/> Sneezing	<input type="checkbox"/> Itchy watery burning eyes