

PATIENT HISTORY QUESTIONNAIRE/REVIEW OF SYSTEMS

NAME _____

Who referred you? _____ Reason _____

Symptoms: _____

For how long? _____

What treatment have you received? _____

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

| | | | |
|---------------------------------------|--|---|---|
| Constitutional | <input type="checkbox"/> Weight loss | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Fever |
| Eyes | <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Double vision | <input type="checkbox"/> Eye pain |
| Ears, Nose, Throat & Mouth | <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 |
| Cardiovascular | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Palpations |
| Respiratory (Lungs) | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Cough |
| | <input type="checkbox"/> Coughing blood | | |
| Gastrointestinal (Stomach) | <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 |
| Genitourinary | <input type="checkbox"/> Urgency | <input type="checkbox"/> Frequency | <input type="checkbox"/> Pain when urinating |
| Integumentary (Skin) | <input type="checkbox"/> New skin lesions | <input type="checkbox"/> Pigmentation changes | <input type="checkbox"/> Changes to existing skin lesions |
| Neurological (Nerves) | <input type="checkbox"/> Tremors | <input type="checkbox"/> Seizures | <input type="checkbox"/> Loss of balance |
| | <input type="checkbox"/> Tingling or numbness | | |
| Musculoskeletal | <input type="checkbox"/> Joint pain | <input type="checkbox"/> Joint swelling | <input type="checkbox"/> Muscle pain |
| Endocrine | <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 |
| Psychiatric | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Depression | <input type="checkbox"/> Difficulty sleeping |
| Hematologic/ Lymph Nodes | <input type="checkbox"/> Easy bleeding | <input type="checkbox"/> Easy bruising | <input type="checkbox"/> Lymph node enlargement or tenderness |
| Allergic/Immunologic | <input type="checkbox"/> Reaction to anesthesia | <input type="checkbox"/> Sneezing | <input type="checkbox"/> Itchy watery burning eyes |