



Name: _____ Date: _____

Date of Birth: _____ MR# _____

Reason for Visit: _____

Comprehensive Medical/Surgical/Family/Social History performed during previous encounter was re-examined and reviewed with patient. Refer to Past Medical/Surgical/Family/Social History dated: _____

Review of Systems: (please check all that apply)

General: Fever Sweats Chills Weight loss Weight gain Depression Fatigue/Tiredness

Eyes: Blurred vision Double vision

Ears: Hearing loss Pain Pressure Drainage Ringing Itching Wax Dizziness
Noise Exposure

Nose: Trauma Surgery Blockage/Congestion Nosebleeds Post nasal drip Snoring Loss of smell Sneezing Itching Other _____

Throat/Neck: Soreness Frequent infection Pain/difficulty on swallowing Lump Hoarseness
Other: _____

Sinus: Pain Pressure Frequent infection

Mouth: Ulcers Sores Dental surgery Loss of taste Dryness Bad breath

Chest: Congestion Cough Wheezing Shortness of breath Pain Phlegm or mucous

Cardiac: Chest pain Palpitations Lightheadedness Prior heart surgery

GI: Heartburn Belching Nausea Vomiting Diarrhea Blood

Roomed by:	
Weight:	Height:
BP:	Temp: