Patient Name:

Date of Birth:

Date:_____

MAIN CONCERN _____

_____

REVIEW OF SYSTEMS – Please circle any of the following that has been a problem for you or your child since your last visit.

General	**Eyes**	**ENT**	**Respiratory**
Fatigue Fever Night sweats New diagnosis of cancer	Blurry vision Itchy eyes Red eyes Tearing Change in vision Glaucoma	Hearing loss Ringing in ears Nose bleeds Nasal drainage Sinus problems Sore throat Hoarseness Snoring Loss of smell Nasal polyps	Cough Shortness of breath Wheezing History of pneumonia
Heart	**Digestive**	**Skin**	**Musculoskeletal**
Chest pain Feet swelling Heart murmur Fast heart rate Palpitations	Abdominal pain Constipation Heartburn/indigestion Nausea Vomiting Diarrhea Blood in stool	Acne Dry skin Itching Rash Sores Hives Swelling Hair loss Psoriasis	Joint swelling Joint pain Muscle aches Back pain Arthritis
Neurological	**Endocrine**	**Blood/Lymph**	**Urinary**
Behavior problems Learning problems Daytime sleep Dizziness Fainting Headache Seizure Memory loss	Cold intolerance Heat intolerance Excessive thirst Weight gain Weight loss	Anemia Swollen lymph node Unusual bleeding Unusual bruising	Painful urination Frequent urination Frequent infections
Psych/Social	**Reproductive**	**Environment**	
Anxiety Depression Drug/Alcohol Stress Sleep problems	Pregnancy Planning pregnancy? Fertility problems Menopause symptoms	New pets Loss of pets How many cats _____ How many dogs _____ Other pets?_____ Other changes at home?	

FAMILY HISTORY:	Nasal Allergy	Asthma	Skin Allergy	Food Allergy	Other:
Mother	□	□	□	□	□
Father	□	□	□	□	□
Sister	□	□	□	□	□
Brother	□	□	□	□	□
Daughter	□	□	□	□	□
Son	□	□	□	□	□