PDX ENT & AUDIOLOGY MEDICAL GROUP

Review of Systems

Name: _____ Date: _____

Height: _____ Weight: _____

Please check **yes** or **no** if you CURRENTLY have the following symptoms: ☑

ENT	Yes	No		Yes	No
Hearing Loss	☐	☐	Facial pain	☐	☐
Ringing in the ears	☐	☐	Loss of smell	☐	☐
Room spinning dizziness	☐	☐	Postnasal drip	☐	☐
Ear pain	☐	☐	Snoring	☐	☐
Ear discharge	☐	☐	Difficulty swallowing	☐	☐
Runny nose	☐	☐	Pain with swallowing	☐	☐
Problem with nasal breathing	☐	☐	Hoarseness	☐	☐
Itchy nose	☐	☐	Nosebleeds	☐	☐
Lump in neck	☐	☐		☐	☐

Neurologic	Yes	No	Cardiovascular	Yes	No
Headaches	☐	☐	Chest pain	☐	☐
Numbness	☐	☐	Irregular heartbeat	☐	☐
Weakness	☐	☐	Shortness of breath	☐	☐
Blurred vision	☐	☐			
Double vision	☐	☐			

Genitourinary	Yes	No	Musculoskeletal	Yes	No
Frequent urination	☐	☐	Joint pain	☐	☐
Nocturnal urination	☐	☐	Joint swelling	☐	☐
Painful urination	☐	☐	Limited mobility	☐	☐

Skin	Yes	No	Psychiatric	Yes	No
Dry skin	☐	☐	Sadness	☐	☐
Concerning mole	☐	☐	Abnormal mood	☐	☐
Itchy skin	☐	☐	Insomnia	☐	☐
			Anxiety	☐	☐

General	Yes	No
Fever	☐	☐
Recent weight loss	☐	☐
Night sweats	☐	☐
Fatigue	☐	☐