ENT Partners of Texas

Patient: _____ **Date:** _____

Review of Systems-Adult Male/Female

Circle Response

Yes	No	
Constitutional		
Y	N	fever
Y	N	daytime sleepiness
Y	N	weight loss (unintentional)
Y	N	weight gain (unintentional)
Eyes		
Y	N	itchy eyes
Y	N	eye drainage
Ears/Nose/Throat		
Y	N	decreased hearing
Y	N	ringing in ears
Y	N	frequent ear infections
Y	N	nosebleeds
Y	N	nasal congestion
Y	N	sneezing
Y	N	itchy nose
Y	N	itchy throat
Y	N	frequent sore throat
Y	N	prolonged hoarseness
Cardiovascular		
Y	N	chest pain
Y	N	palpitations
Respiratory		
Y	N	cough (chronic)
Y	N	snoring
Gastrointestinal		
Y	N	difficulty swallowing
Y	N	heartburn
Genitourinary		
Y	N	blood in urine
Musculoskeletal		
Y	N	muscle weakness
Y	N	joint pain/stiffness
Y	N	back pain
Integumentary		
Y	N	rashes
Y	N	eczema
Neurological		
Y	N	frequent headaches
Y	N	difficulty sleeping
Y	N	problems with balance
Hematologic/Lymphatic		
Y	N	easy bruising
Y	N	excessive bleeding
Y	N	enlarged lymph nodes
Endocrine		
Y	N	excessive appetite
Y	N	heat/cold intolerance
Y	N	excessive sweating
Allergic/Immunologic		
Y	N	problems with anesthesia
Psychiatric		
Y	N	depression
Y	N	memory loss
Y	N	difficulty speaking

_____
Signature of person completing form

_____
Printed name

_____
Relationship to patient