REVIEW OF SYSTEMS - please check any current symptoms

Patient Name: _____ Patient Date of Birth (MM/DD/YYYY): _____

Date: _____

ENT

- ☐ Head/Neck bleeding
- ☐ Difficulty breathing
- ☐ Dry mouth
- ☐ Throat pain
- ☐ Trouble swallowing
- ☐ Hoarseness
- ☐ Foul smell
- ☐ Loss of sense of smell
- ☐ Nasal obstruction
- ☐ Post nasal drip
- ☐ Runny nose
- ☐ Mouth lesions
- ☐ Pain with swallowing
- ☐ Mouth ulcers
- ☐ Ear pain
- ☐ Ear discharge
- ☐ Hearing loss
- ☐ Ringing in ears (tinnitus)

Respiratory

- ☐ Noisy breathing (stridor)
- ☐ Wheezing
- ☐ Cough
- ☐ Shortness of breath
- ☐ Increased sputum
- ☐ Coughing up blood

Musculoskeletal

- ☐ Neck mass
- ☐ Neck stiffness

Cardiovascular

- ☐ Chest pain
- ☐ Increased heart rate

General/Constitutional

- ☐ Fatigue
- ☐ Fever
- ☐ Night sweats
- ☐ Unplanned weight gain
- ☐ Unplanned weight loss

Endocrine

- ☐ Cold intolerance
- ☐ Dry hair
- ☐ Dry skin
- ☐ Heat intolerance
- ☐ Increased hunger

Eyes

- ☐ Blurry vision
- ☐ Double vision
- ☐ Eye swelling
- ☐ Redness

GI/GU

- ☐ Indigestion
- ☐ Vomiting
- ☐ Painful urination or difficulty urinating
- ☐ Increased urinary frequency

Skin

- ☐ Easy bruising
- ☐ Skin lesions
- ☐ Rash
- ☐ Itching

Neurological

- ☐ Dizziness
- ☐ Headaches
- ☐ Memory loss
- ☐ Tremor
- ☐ Vertigo

DO YOU HAVE ANY OF THE FOLLOWING:

- ☐ Allergy to Adhesive
- ☐ Allergy to Latex
- ☐ Allergy to Shellfish or Iodine
- ☐ Blood Thinning medications
- ☐ Internal Defibrillator
- ☐ Joint Replacement
- ☐ Mechanical Heart Valve
- ☐ Internal Pacemaker
- ☐ Pregnant or Planning Pregnancy
- ☐ History of radiation therapy