EASTERN SHORE
ENT & Allergy
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REVIEW OF SYSTEMS

_____ / _____ / _____
(Today's Date)

Patient Name _____

D.O.B. _____ S.S.N. _____

Are you having any of the following symptoms TODAY?

Please circle "Yes" or "No" only.

GENERAL/CONSTITUTIONAL

Change in appetite	Yes	No
Chills	Yes	No
Fever	Yes	No

GASTROINTESTINAL

Abdominal pain	Yes	No
Blood in stool	Yes	No
Change in bowel habits	Yes	No
Constipation	Yes	No
Nausea	Yes	No
Vomiting	Yes	No

ALLERGY/IMMUNOLOGY

Hives	Yes	No
Itching	Yes	No
Rash	Yes	No
Wheezing	Yes	No
History of immune deficiency	Yes	No

MUSCULOSKELETAL

Carpel tunnel	Yes	No
Muscle aches	Yes	No

OPHTHALMOLOGIC

Blurred vision	Yes	No
Dry eye	Yes	No
Pain	Yes	No

PERIPHERAL VASCULAR

Ulceration of feet	Yes	No

SKIN

Hives	Yes	No
Itching	Yes	No
Rash	Yes	No

ENDOCRINE

Cold intolerance	Yes	No
Excessive thirst	Yes	No
Frequent urination	Yes	No
Heat intolerance	Yes	No
Weight loss	Yes	No

NEUROLOGIC

Tics	Yes	No
Loss of the use of an extremity	Yes	No
Tremor	Yes	No

RESPIRATORY

Coughing up blood	Yes	No
Pain with breathing in	Yes	No
Sputum production	Yes	No
Wheezing	Yes	No

PSYCHIATRIC

Mental or physical abuse	Yes	No
Delusions	Yes	No

CARDIOVASCULAR

Chest pain at rest	Yes	No
Difficulty lying flat	Yes	No
Irregular heartbeat	Yes	No

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