Review of Systems/Medical & Family History Update

GREENWOOD EAR | NOSE | THROAT

Patient Name: _____ Date: _____

Required for questions for insurance compliance

Yes	No		Yes	No		Yes	No	
☐	☐	Do you have an advance directive?	☐	☐	Had a flu shot this year?	☐	☐	Have you or members of your family recently been hospitalized for any reason?
☐	☐	Are you a victim of violence or abuse?	☐	☐	Had a pneumonia shot?			

Name of primary care provider (for correspondence): _____

Please indicate below, are you currently experiencing any of these symptoms

Yes	No	General, Constitutional
		Good general health lately
		Recent weight change
		Fever
		Fatigue
		Eyes & Vision
		Eye disease or injury
		Wear glasses or contact lenses
		Blurred or double vision
		Glaucoma
		Ears, Nose & Throat
		Hearing loss
		Ringing in the ears
		Earaches or drainage
		Sinus problems
		Nose Bleeds
		Mouth sores
		Bleeding gums
		Bad breath or bad taste
		Sore throat or voice change
		Swollen glands in neck
		Heart & Cardiovascular
		Heart trouble
		Chest pain
		Sudden heartbeat changes
		Respiratory
		Frequent coughing
		Spitting blood
		Shortness of breath
		Asthma or wheezing
		Gastrointestinal
		Loss of appetite
		Change in bowel movements
		Nausea or vomiting
		Frequent diarrhea
		Painful bowel movements or constipation
		Blood in stool
		Stomach pain
		Genitourinary
		Frequent urination
		Burning or painful urination
		Blood in urine
		Change in force or strain with urination
		Incontinence or dribbling
		Kidney stones
		Sexual difficulty
		Painful periods
		Irregular periods
		Vaginal discharge
		If you have not had a hysterectomy, please give the date of your last menstrual period: _____

Yes	No	Musculoskeletal
		Joint pain
		Joint stiffness or swelling
		Weakness of muscles/joints
		Muscle pain or cramps
		Cold extremities
		Difficulty in walking
		Skin & Breasts
		Rash or itching
		Change in skin color
		Change in hair or nails
		Varicose veins
		Breast pain
		Breast lump
		Breast discharge
		Neurological
		Frequent or recurrent headaches
		Light headed or dizzy
		Convulsions or seizures
		Numbness or tingling sensations
		Tremors
		Paralysis
		Stroke
		Head Injury
		Psychiatric
		Memory loss or confusion
		Nervousness
		Depression
		Sleep problems
		Endocrine
		Glandular or hormone problem
		Thyroid disease
		Diabetes
		Excessive thirst or urination
		Heat or cold intolerance
		Dry skin
		Change in hat or glove size
		Hematologic/Lymphatic
		Slow to heal after cuts
		Easily bruise or bleed
		Anemia
		Phlebitis
		Transfusion
		Swollen glands

_____

Patient or Guardian Signature

_____

Physician / PA Signature