Review of Symptoms

Name: _____ DOB: _____ Date: _____
Drug Allergies: _____
Current Medications & Dosage: _____
_____

Please check any of the following that you are **currently** experiencing:

EAR, NOSE & THROAT	○ Bad breath ○ Dental problems ○ Difficulty swallowing ○ Dryness of mouth ○ Earache ○ Facial pain ○ Hoarseness Other:	○ Loss of hearing ○ Nasal congestion ○ Nasal discharge ○ Nosebleeds ○ Snoring ○ Sore throat ○ Tinnitus/Ear ringing
IMMUNOLOGIC	○ Environmental allergies ○ HIV exposure ○ Hives	○ Immune deficiency ○ Persistent infections ○ Strong allergic reactions
CARDIOVASCULAR	○ Palpitations ○ Lightheadedness	○ Chest pain
CONSTITUTIONAL	○ Generally feeling well ○ Chills ○ Loss of appetite ○ Weight gain	○ Fever ○ Headache ○ Tired ○ Weight loss
ENDOCRINE/HEME/ONC	○ Hot flashes ○ Excessive sweating ○ Excessive thirst ○ Jaundice	○ Hair problems ○ Night sweats ○ Temperature intolerance ○ Bleeding disorder
EYES	○ Blurred vision ○ Cataracts	○ Double vision
GASTROINTESTINAL	○ Constipation ○ Heartburn	○ Diarrhea ○ Ulcer
GENITOURINARY	○ Burning on urination ○ Hesitancy	○ Kidney stones ○ Frequent urination
HEMATOLOGIC	○ Easy bleeding tendency ○ Easy bruising tendency	○ Excessive bleeding ○ Swollen lymph nodes
NEUROLOGICAL	○ Difficulty walking ○ Dizziness ○ Headache ○ Memory loss ○ Numbness	○ Seizures ○ Speech difficulties ○ Tingling ○ Tremors ○ Weakness
MUSCULOSKELETAL	○ Arthritis ○ Back pain ○ Bone pain ○ Joint pain	○ Joint stiffness ○ Joint swelling ○ Leg pain ○ Muscle aches
PSYCHIATRIC	○ Anxiety ○ Depression	○ Hallucinations ○ Sleep disturbances
RESPIRATORY	○ Cough ○ Coughing up sputum	○ Difficulty breathing ○ Shortness of breath ○ Wheezing

Southeast Michigan Ear, Nose and Throat

Dr. Danny Kewson Dr. Roger Toma Dr. Mark Toma
Tania Caballero, ACNP Deana Yasso-Vander Vliet, FNP Karen Bochenek, FNP

Past Medical History

- ○ Anemia
- ○ Anxiety
- ○ Arthritis
- ○ Asthma
- ○ Cholesterol
- ○ Cancer
  Type_____
- ○ Cardiovascular Disease
- ○ Depression
- ○ Developmental Problems
- ○ Diabetes
- ○ Difficulty Breathing
- ○ Ear Infection
- ○ Eczema
- ○ Emphysema
- ○ GERD
- ○ Glaucoma
- ○ Hay Fever
- ○ Headaches
- ○ Hearing Loss
- ○ Heart Attack
- ○ Heart Failure
- ○ Heart Problems
- ○ Hepatitis
- ○ Hernia
- ○ High Blood Pressure
- ○ Hypothyroidism
- ○ Injury
- ○ Kidney Infections
- ○ Language Barriers
- ○ Liver Disease
- ○ Meningitis
- ○ Mental Illness
- ○ Reflux/Heartburn
- ○ Peptic Ulcer
- ○ Seizures
- ○ Multiple Sclerosis
- ○ Sinusitis
- ○ Sleep Apnea
- ○ Snoring
- ○ Shortness of Breath
- ○ Stroke
- ○ Swelling
- ○ Thyroid Disease
- ○ TIA
- ○ Tonsillitis
- ○ Tuberculosis

HIV/STD POSITIVE:
Yes_____ No_____

Recent Hospitalization_____
Other Medical History_____

Tobacco Assessment: Smoking Status

Are you a current smoker? Yes_____ No_____ If yes, start date_____ Pack(s) per day_____
Are you a former smoker? Yes_____ No_____ If yes, quit date_____

Social History

Alcohol Use: Non-Drinker_____ Occasional Drinker_____ Heavy Drinker_____ Former Drinker_____
Illicit Drug Use: Yes_____ No_____ If yes, what drug? _____
Noise Exposure: Yes_____ No_____ If yes, do you use hearing protection? Yes_____ No_____
Exercise: Yes_____ No_____ If yes, how often? _____ Caffeine Servings per day: _____
Occupation: _____

Family History

- ○ Allergies
- ○ Alcoholism
- ○ Anemia
- ○ Asthma
- ○ Bleeding Disorder
- ○ Cancer (Type_____)
- ○ Congestive Heart Failure
- ○ Depression
- ○ Diabetes
- ○ Drug Use
- ○ GERD
- ○ Hearing Loss
- ○ Hypertension
- ○ Mental Illness
- ○ Obesity
- ○ Stroke
- ○ Thyroid Disease
- ○ Tuberculosis

Other Family History: _____

Surgical/Procedural

- ○ No prior surgical history
- ○ Appendectomy
- ○ Back/Neck surgery
- ○ Brain surgery
- ○ Breast surgery
- ○ Cataract surgery
- ○ Cancer surgery
- ○ Ear surgery
- ○ GYN/OB surgery
- ○ Gall bladder
- ○ Heart surgery
- ○ Hemorrhoids
- ○ Hernia
- ○ Hysterectomy
- ○ Orthopedic surgery
- ○ Rhinoplasty
- ○ Septoplasty
- ○ Stomach
- ○ Sinus surgery
- ○ Thyroid
- ○ Tonsil/Adenoidectomy
- ○ Tubal Ligation

Other Surgical Procedures: _____