Primary Health℠ Medical Group

ENT Review of Systems Update

Name:	**Date of Birth:**
Date:	**Patient's Preferred Name:**
Occupation:	

Exposed to: ☐ Cigarette/cigar smoke ☐ Animals/Pets ☐ Toxic Chemicals

Substance Use: ☐ None

☐ Tobacco _____ years Daily amount _____ Quit _____ years ago

☐ Alcohol daily amount _____ Do you/have you had a drinking problem? ☐ Yes ☐ No

☐ Recreational drugs type and frequency

Please assist us in keeping your medical record current by filling out this form. Check yes or no next to each item.
If an entire category/system does not apply check *none* next to that category.

Head/Eyes	None ☐	
	Yes	No
Visual Changes	☐	☐
Light Sensitivity	☐	☐
Blurred Vision	☐	☐
Double Vision	☐	☐
Headaches	☐	☐

ENT	None ☐	
	Yes	No
Sores in mouth or throat	☐	☐
Face or neck lumps	☐	☐
Nose Bleeds	☐	☐

Respiratory	None ☐	
	Yes	No
Cough	☐	☐
Wheezing	☐	☐
Coughing up Blood	☐	☐
Snoring	☐	☐

Cardiovascular	None ☐	
	Yes	No
Chest Pain	☐	☐

Musculoskeletal	None ☐	
	Yes	No
Hand/Foot Swelling	☐	☐
Back or neck problems	☐	☐

Blood/Lymph	None ☐	
	Yes	No
Easy Bleeding	☐	☐

Skin	None ☐	
	Yes	No
Bruising	☐	☐
Rashes	☐	☐
Skin Lesions or abnormalities	☐	☐

Gastrointestinal	None ☐	
	Yes	No
Stomach pain	☐	☐
Weight Gain	☐	☐
Weight Loss	☐	☐
Nausea	☐	☐
Vomiting	☐	☐
Diarrhea	☐	☐

Psychiatric	None ☐	
Feelings of:	Yes	No
Depression	☐	☐
Anxiety	☐	☐

Endocrine	None ☐	
	Yes	No
Heat or Cold Intolerance	☐	☐

Neurological	None ☐	
	Yes	No
Muscle Weakness	☐	☐
Numbness/Tingling	☐	☐
Dizziness/Instability	☐	☐
Light Headedness	☐	☐

Other