WELLSTAR Medical Group

Ear, Nose & Throat

Name:_____ DOB:___/____/____

Review of systems

(Please "X" any that you have experienced in the past 2-4 weeks)

Constitution		Respiratory		Neurological	
Activity Change		Apnea		Difficulty speaking	
Appetite Change		Chest tightness		Dizziness	
Chills		Choking		Facial asymmetry	
Excessive Sweating		Cough		Fainting	
Fatigue		Shortness of breath		Headaches	
Fever		Stridor		Light headedness	
Unexpected weight change		Wheezing		Numbness	
				Seizures	
HENT		**Cardio**		Tremors	
Congestion		Chest pain		Weakness	
Dental problems		Leg swelling			
Drooling		Palpitations		**Hematologic**	
Ear discharge				Enlarged lymph nodes	
Ear pain		**GI**		Bruises/bleeds easily	
Facial swelling		Abdominal distention			
Hearing loss		Abdominal pain		**Psychiatric**	
Mouth sores		Anal bleeding		Agitation	
Neck pain		Blood in stool		Behavior problems	
Nosebleeds		Constipation		Confusion	
Postnasal drip		Diarrhea		Decreased concentration	
Runny nose		Nausea		Depressed	
Sinus pressure		Rectal pain		Hallucinations	
Sneezing		Vomiting		Hyperactive	
Sore throat				Nervous/anxious	
Tinnitus		**Endocrine**		Self-injury	
Trouble swallowing		Cold intolerance		Sleep disturbance	
Voice change		Heat intolerance		Suicidal thoughts	
		Excessive swallowing			
EYES		Excessive thirst		**Allergies**	
Eye discharge		Excessive urination		Environmental allergy	
Eye itching				Food allergy	
Eye pain		**Muscular**		Immunocompromised	
Eye redness		Back pain			
Sensitive to light		Difficulty walking			
Visual disturbance		Joint swelling			
		Muscle pain			
GU					
Decreased urination		**Skin**			
Difficulty urinating		Color Change			
Flank pain		Rash			
Frequency with urination		Wound			