ENT
EAR, NOSE & THROAT ASSOCIATES, P.C.

PATIENT REVIEW OF SYSTEMS

Name: _____ **Referring Physician:** _____

Date Of Birth: _____ **Appointment Date:** _____ **Preferred Pharmacy:** _____
Address/city: _____

History:

Do/Did you smoke/chew tobacco?: ☐ Never smoked ☐ Current every day smoker ☐ Current occasional smoker
☐ Former smoker **Type:** ☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Smokeless
If current did you quit within the last 12 months?: ☐ Yes ☐ No **Date Quit:** _____ **Age Started:** _____
Patient Language: ☐English ☐Spanish ☐French ☐Creole ☐Other
Patient Race: ☐ American Indian ☐ Asian ☐Black/African American ☐Hawaiian ☐ White ☐Other
Patient Ethnicity: ☐Hispanic/Latino ☐Not Hispanic/Latino
Do you use alcohol?: ☐ Yes ☐ No ☐ Rarely # of Drinks per day: _____ per week: _____
Drug use: ☐ Yes ☐ No **Type:** _____ **Frequency:** _____
Occupation: _____
Have you had exposure to dust, fumes, etc? ☐ Yes ☐ No **Type of Work:** _____
Have you had a recent change in your home/work environment? ☐ Yes ☐ No
(new carpet, new home, new drapes, etc.explain):_____

Past Medical History: *(list all past and current medical problems)*

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

Past Procedures/Surgeries/Hospitalization History:

☐ None

Description: _____ **Description:** _____
Description: _____ **Description:** _____
Description: _____ **Description:**_____

If over age 50 have you had a colonoscopy to test for colon cancer? ☐ Yes ☐ No **If yes, date:** _____
If female over age 40 have you had a mammogram to screen for breast cancer?: ☐ Yes ☐ No **If yes, date:** _____

Medications: *(List all current and occasional medications and dosages)*

☐ None

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

Allergies: *(List allergies to any medications, foods, x-ray dye, etc. - also list type of reaction)*

☐ None

1. _____ 3. _____
2. _____ 4. _____

Family History: *(Circle any conditions of any blood relative)*

☐ None ☐ Adopted

	Which Relative?		Which Relative?
Allergy	_____	**Cancer**	_____
Diabetes	_____	**High Blood Pressure**	_____
Stroke	_____	**Heart Disease**	_____
Heart Attack	_____	**Bleeding Disorder**	_____
Thyroid Disease	_____	**Hearing Loss**	_____

Review of Systems: *(each line must have either a yes or no response)*

asthma	☐ Yes	☐ No	**short of breath**	☐ Yes	☐ No	**dizzy**	☐ Yes	☐ No
heart failure	☐ Yes	☐ No	**easy bruising/bleeding**	☐ Yes	☐ No	**HIV**	☐ Yes	☐ No
heart attack	☐ Yes	☐ No	**seizures**	☐ Yes	☐ No	**depression/anxiety**	☐ Yes	☐ No
COPD	☐ Yes	☐ No	**stroke**	☐ Yes	☐ No	**muscle/joint pain**	☐ Yes	☐ No
diabetes	☐ Yes	☐ No	**headaches**	☐ Yes	☐ No	**tuberculosis**	☐ Yes	☐ No
hepatitis	☐ Yes	☐ No	**skin cancer**	☐ Yes	☐ No	**mitral valve prolapse**	☐ Yes	☐ No
high blood pressure	☐ Yes	☐ No	**stomach/digestive problems**	☐ Yes	☐ No	**vision Loss**	☐ Yes	☐ No
Elevated cholesterol	☐ Yes	☐ No	**Kidney/bladder problems**	☐ Yes	☐ No			

Patient Signature: _____