Name: ____Date:____________________

Date of Birth:______________________________ MR# ____________________

Reason for Visit: ____

Comprehensive Medical/Surgical/Family/Social History performed during previous encounter was re-examined and reviewed with patient. Refer to Past Medical/Surgical/Family/Social History dated: ____________________

Review of Systems: (please check all that apply)
General: __Fever __Sweats __Chills __Weight loss __Weight gain __Depression __Fatigue/Tiredness
Eyes: __Blurred vision __Double vision
Ears: __Hearing loss __Pain __Pressure __Drainage __Ringing __Itching __ Wax __Dizziness __Noise Exposure
Nose:__Trauma __Surgery __Blockage/Congestion __Nosebleeds __Post nasal drip __Snoring __Loss of smell __Sneezing __Itching __Other____
Throat/Neck: __Soreness __Frequent infection __Pain/difficulty on swallowing __Lump __Hoarseness Other: ____
Sinus: __Pain __Pressure __Frequent infection
Mouth: __Ulcers __Sores __Dental surgery __Loss of taste __Dryness __Bad breath
Chest: __Congestion __Cough __Wheezing __Shortness of breath __Pain __Phlegm or mucous
Cardiac: __Chest pain __Palpitations __Lightheadedness __Prior heart surgery
GI: __Heartburn __Belching __Nausea __Vomiting __Diarrhea __Blood

Roomed by:	
Weight:	Height:
BP:	Temp: