Patient Name:_____**Date:**_____

Referring Physician:_____ **DOB:**_____

Please circle your answer below:

DO YOU HAVE AN ADVANCED DIRECTIVE YES or N O DO WE HAVE A COPY YES or NO

Review of Systems:

Please check all problems that you have OR Please check "None"

Constitutional: □*None* □fevers (how high? ____) □chills □ Are you pregnant? Y / N (If yes, how far along: _____)

ENT: □*None* Ear**:** □pain □discharge □lump □hearing loss □tinnitus **(circle one)** left/right/both
Nose: □pain □discharge □lump □loss of smell □stuffy **(circle one)** left/right/both
Mouth: □pain □discharge □lump □loss of taste □cavities □dentures
Throat: □pain □lump □thick mucus □tickle □cough □trouble swallowing □hoarse voice

Sleep Apnea Had a sleep study within a year? YES/NO Have a CPAP or sleep machine? YES/ NO
Treating Physician: _____
Facility where sleep study performed: _____Approximate date: _____

Pain:_____(0-10 scale) Staff Add to Vitals

Cardiovascular: □*None* □chest pain □ heart racing

Respiratory: □*None* □ cough □ wheezing □ shortness of breath

GI: □*None* □diarrhea □vomiting

Neuro: □*None* □headache □vision changes □dizziness

Peripheral Vascular: □*None* □painful extremities

Skin: □*None* □ skin rash(where?_____) □ itching (where?_____)

Endocrine: □*None* □always cold □ always hot □ excessive thirst

Allergic/Immuno: □*None* □sneezing □itching □runny nose □frequent colds/infections □history of HIV

2) *Please sign here:*

The responses above are accurate to the best of my knowledge:_____
(P**atient-18 years of age or older, if under age parent or guardian signature**)

_____
(date)

If you are not the patient, please print your *name* _____

and *relationship to the patient*:_____

Please do not write below this line

Date updated; _____ Reviewed by: (initials) **□BJB □LVC □PBS □CFA □DPN □GA(B)P □RRM □NP □RF □HB 01/05/18**