NorthOaks ENT & Allergy
A Clinic of North Oaks Health System

REVIEW OF SYMPTOMS

Date:____/____/_____ Age:_____ Gender: ❑ Male ❑ Female Race:_____

Patient's Name: _____

Place a check in each blank that applies to the patient.

Body
Fever___ Chills___ Weight Loss___ Malaise___ Night Sweats___
Body Aches___

Eyes
Vision Loss___ Double Vision___ Blurred Vision___ Dryness___
Itching Eyes___ Pain___ Struck in Eye___

Ears
Pain___ Pressure___ Popping___ Ringing or Buzzing___
Drainage___ Frequent Infections___ Itching___ Wax Accumulation___
Hearing Loss___ Rt___ Lt___ Both___
Ear Surgery___ Rt___ Lt___ Both___
Surgery:_____

Nose
Trauma___ Obstruction___ Drainage___ Post-nasal Drip___
Snoring___ Loss of Smell___ Tooth Pain___ Bleeding___
Sneezing___ Facial Pressure of Headaches___

Mouth/Throat
Soreness___ Frequent Infections___ Painful Swallow___
Difficult Swallow___ No Teeth___ Ulcers___

Neck
Masses___ Pain___ Tenderness___

Cardiovascular
Chest Pain___ Palpitations___ Murmur___

Respiratory
Shortness of Breath___ Cough___ Wheezing___ Coughing Blood___

Gastrointestinal
Nausea___ Vomiting___ Diarrhea___ Bloody Stool___

Urinary
Painful Urination___ Bleeding___ Difficult Urination___

Musculoskeletal
Muscle Weakness___ Joint Pain___

Skin
Rash___ Itching___ Growth on Skin___

Neurological
Numbness___ Paralysis___ Headache___ Tremor___

Psychiatric
Paranoia___ Depression___ Anxiety___ Hallucinations___
Hear Voices___

Endocrine
Hair Loss___ Nervousness___ Tremor___

Hematology/Lymph
Easy Bruisability/Bleeding___ Enlarged Glands___

Allergic
Hay Fever___ Food Intolerance___ Insects___ Chemical___
Explain:_____

Drug Allergies:_____
_____
_____
_____

Past Medical History:
Place a check in each blank that applies to the patient. and/or family member.

	Patient	Family
Diabetes	_____	_____
High Blood Pressure	_____	_____
Thyroid Disease	_____	_____
Heart Disease	_____	_____
Stroke	_____	_____
Asthma	_____	_____
Bronchitis	_____	_____
Hepatitis	_____	_____
Tuberculosis	_____	_____
HIV	_____	_____
Hearing Loss	_____	_____
Other	_____	_____

Current Medications:
_____
_____
_____
_____

Past Surgical History:
_____
_____
_____
_____

Social History:
Occupation_____
Tobacco Use____ packs per day for ____ years
____ Cigarettes ____ Chewing Tobacco
Alcohol Use____ glasses per day for____ years
Caffeine____ ounces per day (Coffee/Tea)
Sun Exposure____ hours per day for____ years
Loud Noise Exposure____ hours per day
____ Industrial ____Hunting ____Music

_____ ___/___/_____
Patient's Signature Date

History Reviewed:
_____, M.D. ___/___/_____
Date