

REVIEW OF SYSTEMS

Name: _____ **Date of Birth:** _____ **Date:** _____

Ears *(Explain on lines provided)*

Yes No Earaches: _____

Yes No Ringing: _____

Yes No Hearing loss: _____

Yes No Hearing aids: _____

Nose and Sinus

Yes No Nosebleeds: _____

Yes No Sneezing: _____

Yes No Hayfever/Allergies: _____

Mouth and Throat

Yes No Frequent sore throats: _____

Yes No Bleeding gums: _____

Yes No Hoarseness: _____

Yes No Swelling: _____

Yes No Thyroid problems: _____

Yes No Dentures: _____

Neuro

Yes No Numbness: _____

Yes No Tingling: _____

Yes No Fainting: _____

Yes No Headaches: _____

Yes No Dizziness: _____

Yes No Seizures: _____

Yes No Stroke: _____

Patient Signature _____