Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Today’s Date: \_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Review of Systems:** Please mark any current problems for you or your child.

**General:**
 No Problems
 Fevers
 Chills
 Sweats
 Anorexia
 Fatigue
 Sleepiness (Awake Time)
 Sleep Problems
 Malaise
 Weight Gain
 Weight Loss
 Speech Delay

**Ears:**
 No Problems
 Itching
 Pain
 Fullness/Pressure
 Hearing Loss
 Wax
 Ringing
 Ear Drainage

**Nose:**
 No Problems
 Obstruction
 Congestion
 Postnasal Drip
 Headache
 Facial Pain
 Bleeding
 Runny Nose
 Cough
 Seasonal Allergies

**Throat:**
 No Problems
 Soreness
 Pain
 Swallowing
 Voice Problems
 Bad Breath
 Snoring
 Heartburn
 Foreign Body
 Tumor

**Skin:**
 No Problems
 Rash
 Itching
 Ulcers/Growths
 Excess Scarring
 Bleeding Problems
 Dryness
 Suspicious Lesions

**Allergic/Immunologic:**
 No Problems
 Hives (Urticaria)
 Hay Fever
 Persistent Infections
 HIV Exposure

**Neurological:**
 No Problem
 Paralysis
 Weakness
 Seizures
 Syncope
 Tremors
 Vertigo

**Vestibular:**
 No Problems
 Imbalance
 Visual Problems
 Double Vision
 Joint Problems
 Spinning Sensation
 Motion Provoked
 Dizziness
 Falling
 Strength Issues

**Eyes:**
 No Problems
 Eye Pain
 Vision Loss
 Excessive Tears
 Blurring
 Double Vision (Diplopia)
 Irritation
 Discharge
 Intolerance to light (Photophobia)

**Neck:**
 No Problems
 Lump/Mass
 Thyroid Problems
 Pain/Tenderness

**Respiratory:**
 No Problems
 Cough
 Dyspnea
 Excessive Sputum
 Blood Sputum (Hemoptysis)
 Wheezing

***Please notify the medical assistant if there are any changes to your current medications, any new diagnoses, surgeries or if you have developed any new allergies since your last visit with our office. Thanks.***