RiverENT
Adult & Pediatric Ear, Nose & Throat Specialists

Patient Name: ______________________________ Date of Birth: ____________ Date of Service: ____________

REVIEW OF SYSTEMS - Are you currently having problems with: (check all that apply)		
General	**Cardiovascular**	**Neurological**
☐ Fever	☐ Chest Pain	☐ Dizziness
☐ Chills	☐ Palpitations (fast heart beat)	☐ Numbness
☐ Night Sweats	☐ Lower Extremity Swelling	☐ Fainting
☐ Feeling Tired (Fatigue)	**Respiratory**	☐ Memory Loss
☐ Recent Weight Gain	☐ Difficulty Breathing	**Psychiatric**
☐ Recent Weight Loss	☐ Wheezing	☐ Depression
Eyes	☐ Cough	☐ Anxiety
☐ Double Vision	☐ Snoring	**Endocrine**
☐ Blurry Vision	☐ Bloody Sputum	☐ Cold Intolerance
☐ Discharge from Eyes	**Gastrointestinal**	☐ Heat Intolerance
☐ Dry Eyes	☐ Vomiting	☐ Excessive Thirst
☐ Eyes Itch	☐ Nausea	**Hematological/Lymphatic**
Ear, Nose, Throat	☐ Blood in Stool	☐ Easy Bruising
☐ Ringing in Ears	☐ Diarrhea	☐ Excessive Bleeding
☐ Loss of Hearing	☐ Constipation	
☐ Nosebleeds	**Skin**	
☐ Nasal Congestion	☐ Rash	
☐ Trouble Swallowing	☐ Skin Lesion Change	☐ ***None***

I certify that the information in this document is, to my knowledge, accurate.

______________________________	______________________________	______________________________
Signature of patient or responsible party	Print name of patient or responsible party	Date