



RIVIERA ENT

Riviera ENT
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NEW PATIENT CURRENT PROBLEMS

Patient's Last Name _____ First Name _____ Middle Initial _____

What brings you in today? _____

REVIEW OF SYSTEMS: Please mark where applicable:

General health problems

- No Yes
- Fatigue
- Fever
- Night sweats
- Weight loss
- Weight gain

Eye problems

- No Yes
- Double vision
- Itchy eyes
- Redness

Ear problems

- No Yes
- Drainage
- Hearing loss
- Infections
- Dizziness
- Itchiness
- Exposure to Excessive Noise
- Ear pain or pressure
- Tinnitus /noise in ears

Nose & Sinus problems

- No Yes
- Congestion
- Facial Pain
- Mouth Breathing
- Nose Bleeds
- Sneezing
- Runny Nose
- Post Nasal Drainage

Mouth & Throat problems

- No Yes
- Difficulty Swallowing
- Sleep Apnea
- Snoring
- Sore Throat
- Hoarseness
- Sores/Ulcers in Mouth

Heart or circulation problems

- No Yes
- Heart Murmur
- Chest pain
- Swelling of Ankles/Edema
- Blacking Out
- Irregular Heartbeat/Palpitations

Lung or respiratory problems

- No Yes
- Cough
- Shortness of Breath
- Wheezing

Musculoskeletal:

- No Yes
- Leg pain

Stomach problems

- No Yes
- Abdominal Pain
- Constipation
- Diarrhea
- Heartburn
- Nausea
- Vomiting

Brain or Nervous system problems

- No Yes
- Headache
- Seizures
- Focal Weakness
- Numbness

Glands & Hormone problems

- No Yes
- Heat Intolerance
- Cold Intolerance
- Neck Enlargement/Goiter

Blood or Lymph nodes problems

- No Yes
- Easy Bleeding
- Easy Bruising

Allergy problems

- No Yes
- Food Allergies
- Bee Sting Allergies
- Environmental Allergies
- Urticaria / Hives

Skin

- No Yes
- Itchy Skin/ Pruritis
- Rash
- Contact Allergy

Other concerns:

Responsible Party Name: _____ Relationship to Patient: _____

Responsible Party Signature: _____ Date: _____