Print in Color or Grayscale Only
Using Adobe Acrobat Reader 8.0 or later

ENT Review of Systems

Please answer every question.

Marking Instructions

Please use a #2 pencil.
Fill in the complete oval as shown...

PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH

Month Day Year

Please mark only the symptoms you are CURRENTLY experiencing.

Mark all that apply. If no symptoms in a category, please mark "NONE."

General	◯ Fever ◯ Chills	◯ NONE
Skin	◯ Rash ◯ Easy Bruising	◯ NONE
HEENT	◯ Blurred Vision ◯ Headache ◯ Migraine	◯ NONE
Heart	◯ Chest Pain ◯ Hypertension (High Blood Pressure)	◯ NONE
Lungs	◯ Cough ◯ Coughing up Blood	◯ NONE
GI	◯ Vomiting ◯ Diarrhea	◯ NONE
Skeletal	◯ Joint Pain ◯ Joint Swelling	◯ NONE
Neuro	◯ Seizure History ◯ Vertigo (Spinning Sensation)	◯ NONE
Endocrine	◯ Excessive Thirst ◯ Dry Skin	◯ NONE
GU	◯ Burning during Urination ◯ Blood in Urine	◯ NONE