Rev 07/11/07

The Ear Institute of Texas, P.A.

Patient Name: ______________________________ Date of Birth: ________________

Review of Systems: Please indicate any personal history below:

Constitutional / General
Fever………………………… Yes No
Weight Loss………………… Yes No
Night Sweats………………… Yes No
Excessive Fatigue………….. Yes No

Eyes
Wear Glasses……………… Yes No
Infections…………………… Yes No
Injuries……………………… Yes No
Glaucoma…………………… Yes No
Cataracts…………………… Yes No
If yes, operated? Yes No
Macular Degeneration……... Yes No
Itchy/watery eyes…………… Yes No

Ear
Wear Hearing Aids………… Yes No
Hearing Loss………………… Yes No
If yes, circle one of the following:
Left / Right / Both Sides
Ear Pain……………………… Yes No
Ringing in the Ears………… Yes No
If yes, circle all that apply:
Left / Right / Both Sides
Rarely / Occasional / Constant
Dizziness…………………….. Yes No
Exposure to Loud Noise…… Yes No
If yes, list:______________________

Nose, Throat, and Mouth
Nose Bleeds…………………. Yes No
Nasal Congestion…………… Yes No
Inability to Smell…………… Yes No
Sinus Problems……………… Yes No
Sinus Headaches…………… Yes No
Sore Throat………………….. Yes No
Hoarseness………………….. Yes No
Difficulties Swallowing…….. Yes No
Speech Delay/Difficulties….. Yes No
Pain Swallowing…………….. Yes No

Respiratory
Chronic Cough………………. Yes No
Emphysema………………….. Yes No
Asthma……………………. Yes No
Shortness of Breath……….. Yes No
Bronchitis……………………. Yes No
Pneumonia…………………… Yes No
Lung Cancer…………………. Yes No
Blood Sputum……………….. Yes No

Cardiovascular
Chest Pain or Angina………. Yes No
Irregular Pulse………………. Yes No
Heart Murmur………………. Yes No
High Cholesterol……………. Yes No
Swelling in Feet or Heads….. Yes No
Leg Pain While Walking…… Yes No

Musculoskeletal
Broken Bones……………….. Yes No
If yes, list:______________________
Arm or Leg Weakness……… Yes No
Back Pain……………………. Yes No
Arm or Leg Pain…………….. Yes No
Joint Pain or Swelling………. Yes No

Integumentary
Skin Disease…………………. Yes No
Skin Cancer………………….. Yes No

Gastrointestinal
Indigestion/Pain with Eating… Yes No
Nausea……………………….. Yes No
Vomiting……………………… Yes No
Liver Disease………………… Yes No
Jaundice……………………… Yes No
Abnormal Pain………………. Yes No
Ulcers or Gastritis…………… Yes No
Colon Cancer………………… Yes No
Heartburn……………………. Yes No
Reflux………………………… Yes No

Genitourinary
Urinary Tract Infections……. Yes No
Blood in Your Urine………… Yes No
Incontinence………………… Yes No
Prostate Cancer (males)……. Yes No
Endometriosis (females)……. Yes No
Uterine/Cervical Cancer………… Yes No

Hematologic/Lymphatic
Anemia……………………………. Yes No
Hemophilia………………………. Yes No
Persistant Swollen Glands……… Yes No
Swollen Lymph Nodes………….. Yes No
Blood Transfusion………………. Yes No
If yes, when?____________________

Psychiatric
Anxiety…………………………… Yes No
Depression………………………. Yes No
Bipolar Disorder…………………. Yes No
Other Psychriatric Disorder…….. Yes No
If yes, please list: _________________

Endocrine
Increased Appetite……………… Yes No
Excessive Thirst/Urination…….. Yes No
Hormone Problems…………. Yes No

Allergic/Immunologic
Immunological Disorders………. Yes No
Food Allergies………………….. Yes No
Inhalant (Nasal) Allergies………. Yes No
Have you been allergy tested?_______

Neurological
Fainting Spells/Black Outs……… Yes No
Seizures…………………………… Yes No
Problems with Memory…………. Yes No
Disorientation……………………. Yes No
Difficulty with Your Speech…….. Yes No
Inability to Concentrate………… Yes No
Double or Blurred Vision……….. Yes No
Face Weakness………………….. Yes No
Poor Coordination in Arms/Legs Yes No
Have you had 2 or more falls in the past year?.......................... Yes No
Have you had any falls in the past year that resulted in injury?.... Yes No
If yes, how many? ______
Weakness in Arms or Legs…….. Yes No
Numbness in Arms or Legs…….. Yes No

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

______________________________ ______________________
Signature of Patient, Parent or Guardian Date

Doctor's Review

______________________________ ______________________
Signature of Doctor Date