BRIAN HUMPHREYS, M.D., F.A.C.S.
OTOLARYNGOLOGY

# REVIEW OF SYSTEMS

DO YOU NOW OR HAVE YOU HAD ANY PROBLEMS RELATED TO THE FOLLOWING SYSTEMS?
CIRCLE YES OR NO. PLEASE EXPLAIN ANY YES ANSWERS IN THE SPACE PROVIDED.

**CONSTITUTIONAL SYMPTOMS**

| | | |
|---|---|---|
| FEVER | Y | N |
| CHILLS | Y | N |
| HEADACHE | Y | N |
| WEAKNESS | Y | N |
| OTHER | | |

**EYES**

| | | |
|---|---|---|
| BLURRED VISION | | |
| DOUBLE VISION | Y | N |
| PAIN | Y | N |
| OTHER | | |

**ALLERGIC / IMMUNOLOGIC**

| | | |
|---|---|---|
| HAY FEVER | Y | N |
| DRUG ALLERGIES | Y | N |
| IMMUNITY DISORDERS | Y | N |
| ARE IMMUNIZATIONS CURRENT? | Y | N |
| OTHER | | |

**ENDOCRINE**

| | | |
|---|---|---|
| EXCESSIVE THIRST | Y | N |
| TOO HOT | Y | N |
| TOO COLD | Y | N |
| TIRED / SLUGGISH | Y | N |
| OTHER | | |

**HEMATOLOGIC / LYMPHATIC**

| | | |
|---|---|---|
| SWOLLEN GLANDS | Y | N |
| BLOOD CLOTTING PROBLEM | Y | N |
| OTHER | | |

**RESPIRATORY**

| | | |
|---|---|---|
| WHEEZING | Y | N |
| FREQUENT COUGH | Y | N |
| SHORTNESS OF BREATH | Y | N |
| OTHER | | |

**CARDIOVASCULAR**

| | | |
|---|---|---|
| CHEST PAIN | Y | N |
| VARICOSE VEINS | Y | N |
| HIGH BLOOD PRESSURE | Y | N |
| HISTORY OF HEART ATTACK? | Y | N |
| OTHER | | |

**INTEGUMENTARY (SKIN)**

| | | |
|---|---|---|
| SKIN RASH | Y | N |
| BOILS | Y | N |
| PERSISTENT ITCH | Y | N |
| OTHER | | |

**NEUROLOGICAL**

| | | |
|---|---|---|
| TREMORS | Y | N |
| DIZZY SPELLS | Y | N |
| NUMBNESS / TINGLNG | Y | N |
| STROKES | Y | N |
| FAINTING | Y | N |
| OTHER | | |

**MUSCULOSKELETAL**

| | | |
|---|---|---|
| JOINT PAIN | Y | N |
| NECK PAIN | Y | N |
| BACK PAIN | Y | N |
| OTHER | | |

**EAR / NOSE / THROAT / MOUTH**

| | | |
|---|---|---|
| EAR INFECTION | Y | N |
| SORE THROAT | Y | N |
| SINUS PROBLEMS | Y | N |
| OTHER | | |

**GENITOURINARY**

| | | |
|---|---|---|
| URINE RETENTION | Y | N |
| PAINFUL URINATION | Y | N |
| URINATION FREQUENCY | Y | N |
| OTHER | | |

**GASTROINTESTINAL**

| | | |
|---|---|---|
| ABDOMINAL PAIN | Y | N |
| NAUSEA / VOMITING | Y | N |
| INDIGESTION / HEARTBURN | Y | N |
| BLEEDING FROM MOUTH OR RECTUM | Y | N |
| OTHER | | |

**PSYCHOLOGIC**

| | | |
|---|---|---|
| ARE YOU GENERALLY SATISFIED WITH LIFE? | Y | N |
| DO YOU FEEL SEVERELY DEPRESSED? | Y | N |
| HAVE YOU CONSIDERED SUICIDE? | Y | N |
| OTHER | | |

**PHYSICIAN USE ONLY: (COMMENTS / NOTES)**

| # ANSWER | LEVEL OF SERVICE |
|---|---|
| 0 - 1 | 1 OR 2 |
| 2 - 9 | 3 |
| 10+ | 4 OR 5 |

PHYSICIAN: _____ DATE: ____ / ____ / ____