

ATLANTIC ENT LLC MICHAEL WIDICK, M.D.

Name:	DATE:		
PATIENT REVIEW OF SYSTEMS			
Do you consider yourself generally: <input type="checkbox"/> Healthy <input type="checkbox"/> Fairly Healthy <input type="checkbox"/> Not Healthy			
Have you ever experienced or are you experiencing any of the following: (Please check all that apply)			
EYES <input type="checkbox"/> None	<input type="checkbox"/> Vision problems <input type="checkbox"/> Macular Degeneration	<input type="checkbox"/> Glaucoma <input type="checkbox"/> Excessive Tearing	<input type="checkbox"/> Cataracts <input type="checkbox"/> Other _____
EARS <input type="checkbox"/> None	<input type="checkbox"/> Hearing Loss <input type="checkbox"/> Ear infections	<input type="checkbox"/> Noise in ear(s) <input type="checkbox"/> Vertigo (spinning)	<input type="checkbox"/> Pressure in ears <input type="checkbox"/> Ear drainage
NOSE/SINUS <input type="checkbox"/> None	<input type="checkbox"/> Runny nose <input type="checkbox"/> Nose bleeds <input type="checkbox"/> Sinus pressure	<input type="checkbox"/> Post-nasal drip <input type="checkbox"/> Loss of smell <input type="checkbox"/> Sinus Headaches	<input type="checkbox"/> Nasal congestion <input type="checkbox"/> Facial pain <input type="checkbox"/> Chronic cough
ORAL CAVITY <input type="checkbox"/> None	<input type="checkbox"/> Bruxism (Teeth Grinding) <input type="checkbox"/> Painful Teeth	<input type="checkbox"/> Sores in Mouth <input type="checkbox"/> Missing Teeth <input type="checkbox"/> Tongue Problems	Teeth condition: Good Fair Poor <input type="checkbox"/> Dentures
PHARYNX (THROAT) <input type="checkbox"/> None	<input type="checkbox"/> Infections <input type="checkbox"/> Pain swallowing	<input type="checkbox"/> Difficulty swallowing food	<input type="checkbox"/> Difficulty swallowing fluids
LARYNX (VOICEBOX) <input type="checkbox"/> None	<input type="checkbox"/> Laryngitis <input type="checkbox"/> Change in voice	<input type="checkbox"/> Cough when swallow	<input type="checkbox"/> Hoarseness <input type="checkbox"/> Vocal Cord Paralysis
NECK <input type="checkbox"/> None	<input type="checkbox"/> Masses <input type="checkbox"/> Surgery	<input type="checkbox"/> Radiation treatments	<input type="checkbox"/> Cysts <input type="checkbox"/> Thyroid Problems
CARDIOPULMONARY (HEART/LUNGS)	<input type="checkbox"/> None <input type="checkbox"/> Cough	<input type="checkbox"/> Chest Pain <input type="checkbox"/> Palpitations	<input type="checkbox"/> Wheezing <input type="checkbox"/> Shortness of breath
GASTROINTESTINAL (STOMACH) <input type="checkbox"/> None	Appetite: Good Fair Poor	<input type="checkbox"/> Difficulty swallowing	<input type="checkbox"/> Heartburn/Acid indigestion or reflux
GENITOURINARY <input type="checkbox"/> None	<input type="checkbox"/> Kidney infections <input type="checkbox"/> Recurrent UTI	<input type="checkbox"/> Stones <input type="checkbox"/> Urinating at night	<input type="checkbox"/> difficulty starting Urinary flow
MUSCULOSKELETAL <input type="checkbox"/> None	<input type="checkbox"/> Serious injuries <input type="checkbox"/> Joint pains	<input type="checkbox"/> Deformities <input type="checkbox"/> Arthritis	<input type="checkbox"/> Loss of Strength
NEUROLOGIC <input type="checkbox"/> None	<input type="checkbox"/> History of weakness <input type="checkbox"/> Imbalance	<input type="checkbox"/> Numbness	<input type="checkbox"/> Headaches
PSYCHIATRIC <input type="checkbox"/> None	<input type="checkbox"/> Mood swings <input type="checkbox"/> Suicidal tendencies	<input type="checkbox"/> Depression	<input type="checkbox"/> Anxiety
INTEGUMENTARY (SKIN) <input type="checkbox"/> None	<input type="checkbox"/> Skin Cancer <input type="checkbox"/> Unusual moles	<input type="checkbox"/> Chronic irritation <input type="checkbox"/> Rashes/Hives	<input type="checkbox"/> Itchy Skin
ENDOCRINE <input type="checkbox"/> None	<input type="checkbox"/> Thyroid disorders <input type="checkbox"/> Hot Flashes	<input type="checkbox"/> Hormone dysfunction <input type="checkbox"/> Heat susceptibility	<input type="checkbox"/> Hair loss <input type="checkbox"/> Cold susceptibility
HEMATOLOGIC <input type="checkbox"/> None	<input type="checkbox"/> Anemia (low blood count)	<input type="checkbox"/> History of Swollen Glands	<input type="checkbox"/> History of bleeding tendencies
ALLERGIC <input type="checkbox"/> None	<input type="checkbox"/> Sneezing <input type="checkbox"/> Watery nose	<input type="checkbox"/> Itchy Eyes <input type="checkbox"/> Itchy Nose	<input type="checkbox"/> "Writable Skin" Atopic Dermatitis