

Patient Name: _____ Date: _____

Referring Physician: _____ DOB: _____

Answer once a calendar year please:

Do you have an Advanced Directive (Living will)? YES NO Do we have a copy? YES NO

Review of Systems:

Please check all problems that you have OR Please check "None"

Constitutional: None fevers (how high? _____) chills Are you pregnant? Y / N (If yes, how far along: _____)

ENT: None Ear: pain discharge lump hearing loss tinnitus (**circle one**) left/right/both
Nose: pain discharge lump loss of smell stuffy (**circle one**) left/right/both
Mouth: pain discharge lump loss of taste cavities dentures
Throat: pain lump thick mucus tickle cough trouble swallowing hoarse voice

Sleep Apnea Had a sleep study within a year? YES/NO Have a CPAP or sleep machine? YES/ NO

Treating Physician: _____

Facility where sleep study performed: _____ Approximate date: _____

Pain: _____ (0-10 scale) Staff Add to Vitals

Cardiovascular: None chest pain heart racing

Respiratory: None cough wheezing shortness of breath

GI: None diarrhea vomiting

Neuro: None headache vision changes dizziness

Peripheral Vascular: None painful extremities

Skin: None skin rash(where? _____) itching (where? _____)

Endocrine: None always cold always hot excessive thirst

Allergic/Immuno: None sneezing itching runny nose frequent colds/infections history of HIV

2) Please sign here:

The responses above are accurate to the best of my knowledge: _____

(Patient-18 years of age or older, if under age parent or guardian signature)

(date)

If you are not the patient, please print your **name** _____

and **relationship to the patient:** _____

Please do not write below this line

Date updated: _____ Reviewed by: (initials) BJB LVC PBS CFA DPN GA(B)P RRM NP RF HB 01/05/18