PNS-9021-FRM
REV 0 12.14.20

Health Overview

Name: ____ Date: _______________________

Do you smoke? ____Yes ____ No Drink alcohol? ____Yes ____ No

How much? _______________ How much? _______________

Use drugs? ____Yes ____ No What kind? _____________________ How much? _______________

Please check which symptoms you frequently experience.

General:	____ Weight Loss How Much? _________	____ Fatigue	____ Sleep Disturbances
Neuro:	____ Spinning Sensation	____ Unsteadiness	____ Headaches
ENT:	____ Hearing Loss	____ Tinnitus	____ Hoarseness
Eyes:	____ Visual Changes	____ Excessive Tearing	____ Dry Eyes
Lungs:	____ Shortness of Breath	____ Cough	____ Wheezing
Heart:	____ Chest Pain	____ Palpitations	____ Heart murmur
GI:	____ Swallowing Difficulties	____ Abdominal Pain	____ Nausea / Vomiting
GU:	____ Frequent Urination	____ Blood in Urine	____ Difficulty Urinating
Skin:	____ Excess Dryness	____ Easy Bruising	____ Swelling / Masses
Immune:	____ Hay Fever / Seasonal Allergies	____ Frequent Infections	____ Food Sensitivities
M/S:	____ Limited Joint Movement	____ Joint Swelling / Pains	____ Muscle Spasms
Endocrine:	____ Hot / Cold Flashes	____ Weight Fluctuations	____ Mood Swings
Heme:	____ Swollen Lymph Nodes	____ Prolonged Bleeding	____ Blood Clots
Psych:	____ Hallucinations	____ Depression	

Level 1 – None Level 2 – 1 System Level 3 – 2-9 Systems Level 4 – 10+ Systems

Is there any information you wish to share? ____
____
____

Primary Physician: ____

Other Physicians: ____
____
____

Reason for today’s visit: ____
____

Have you seen another otolaryngologist for the same problem in the past? _______________________
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