tribeca
ENT & FACIAL PLASTIC SURGERY

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## REVIEW OF SYSTEMS

Please circle all that apply. If none apply, please circle "None" at the top of each box. If circled, please explain.

| | |
|---|---|
| **General: None**<br><br>Current Fever<br>General Fatigue<br>Recent Weight Gain<br>Recent Weight Loss<br>Excess Stres | **Skin: None**<br><br>History of Keloids or Poor Scarring<br>New or Changing Growths<br>Thinning Hair or Hair Loss<br>Receding Hairline<br>History of Cold Sores |
| **Head and Neck: None**<br><br>Recent Changes in Vision<br>Sensation of Heavy Eyelid<br>Upper Eyelid Droop<br>Facial Muscular Weakness<br>Contacts/Glasses<br>Dry Eyes<br>Nose Bleeds<br>Difficulty Breathing Through Your Nose<br>Nasal Allergies or Sinus Disease<br>Snoring | **Respiratory: None**<br><br>Cough<br>Shortness of Breath<br>Wheezing |
| **Cardiovascular: None**<br><br>Current Chest Pain<br>Current Leg Swelling<br>Fast or Irregular Heart Beat<br>Palpitations | **Gastroenterology and Genitourinary: None**<br><br>Current Abdominal Pain<br>Constipation<br>Diarrhea<br>Nausea/Vomiting |
| **Metabolic/Endocrine: None**<br><br>Cold Intolerance<br>Hair Loss<br>Excess Hair<br>Excess Sweating<br>Females: Irregular Periods | **Musculoskeletal: None**<br><br>Joint Pain/Arthritis<br>Muscle Weakness |
| **Hematologic: None**<br><br>Anemia<br>Blood Clots<br>Enlarged Lymph Nodes | **Immunologic: None**<br><br>Frequent Infections<br>Environmental Allergies<br>Food Allergies |

For any circled items, please explain:_____

Are you under the care of a primary care or specialist physician for the above? _____

Please provide the name and contact information of the primary and/or specialist physician managing your symptoms:

Patient Name (print) _____ Signature _____ Date _____