

Follow-up Information

Welcome back to Greenwood, Laurens, Newberry & Abbeville Ear, Nose & Throat Centers
Please help us serve you better by completing this form
before you see the Doctor.

Name: _____ Date: _____

Reason you are seeing the doctor today? _____

Are you better? _____

Any **new** complaints? _____

Any **new** medications or medical problems since last seeing your Doctor? _____

List again your allergies to medications _____

Review of Systems:

General	Yes	No	Nose/Sinus	Yes	No
Fever	<input type="checkbox"/>	<input type="checkbox"/>	Nose bleeds	<input type="checkbox"/>	<input type="checkbox"/>
Chills	<input type="checkbox"/>	<input type="checkbox"/>	Injury	<input type="checkbox"/>	<input type="checkbox"/>
Weight loss	<input type="checkbox"/>	<input type="checkbox"/>	Congestion	<input type="checkbox"/>	<input type="checkbox"/>
Night sweats	<input type="checkbox"/>	<input type="checkbox"/>	Runny nose	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Mouth breathing	<input type="checkbox"/>	<input type="checkbox"/>
Ears	Yes	No	Bad taste or smell	<input type="checkbox"/>	<input type="checkbox"/>
Hearing loss - gradual	<input type="checkbox"/>	<input type="checkbox"/>	Throat	Yes	No
Hearing loss - sudden	<input type="checkbox"/>	<input type="checkbox"/>	Sore throat	<input type="checkbox"/>	<input type="checkbox"/>
Pain	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>
Ringing	<input type="checkbox"/>	<input type="checkbox"/>	Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness or vertigo	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>
Infections	<input type="checkbox"/>	<input type="checkbox"/>	Swollen tonsils	<input type="checkbox"/>	<input type="checkbox"/>

Other information you would like the doctor to know: _____