Patient Check-In Form (ROS)

Patient Name: _____ ***DOB:*** _____

Do you now have or have you recently had any of the following? (circle answer below)

	YES	NO
Fever		
Sleeping Problems		
Unintentional weight gain		
Unintentional weight loss		
Blurred vison		
Eye pain		
Itchy eyes		
Loss of vision		
Nasal congestion		
Frequent nosebleeds		
Post-nasal drainage		
Sneezing		
Belching sour material into throat		
Hoarseness		
Mouth ulcers		
Partials or dentures		
Voice changes		
Ear drainage		
Dizziness		
Hearing loss		
Ear pain		
Ringing in the ears		
Frequent non-productive cough		
Frequent productive cough		
Shortness of breath		
Snoring (excessive)		
Wheezing		
Blacking out or fainting		
Chest pain		
Heart murmur		
Irregular heart beat		
Leg cramps		
Swelling of ankles		

	YES	NO
Abdominal pain		
Diarrhea		
Heartburn		
Nausea		
Painful swallowing		
Trouble swallowing		
Vomiting		
Painful joints		
Stiffness in joints		
Swelling in joints		
Change in sense of smell		
Change in sense of taste		
Headache		
Seizures		
Severe face pain		
Tremor		
Cold Feeling		
Fatigue		
Increased appetite		
Bleed excessively after injury		
Bruise easily		
Masses (lumps) in armpit		
Masses (lumps) in groin		
Masses (lumps) in neck		
Anaphylaxis		
Hives		

Most Recent Flu Vaccine _____
(mm) / (dd) / (yyyy)

Most Recent Pneumonia Vac _____
(mm) / (dd) / (yyyy)

Emergency Contact Name: _____ **Phone #:** _____