

1251 South Cedar Crest Blvd., Suite 110
Allentown, PA 18103
610-770-9797

Name: _____ Date: _____

PLEASE CHECK THOSE SYMPTOMS YOU ARE EXPERIENCING AND SPECIFY DURATION FOR EACH.

EAR SYMPTOMS

- Ringing Right Left
- Pulsing Right Left
- Buzzing Right Left
- Hearing Loss Right Left
- Clogged Right Left
- Discharge Right Left
- Pain Right Left
- Itching Right Left
- Pressure Right Left
- Recurrent infections
- Dizzy (Room spinning)
- Off balance

DURATION OF SYMPTOMS

- Right _____ Left _____
- Right _____ Left _____
- Right _____ Left _____
- Right _____ Left _____
- Right _____ Left _____
- Right _____ Left _____
- Right _____ Left _____
- Right _____ Left _____
- Right _____ Left _____
- _____
- _____
- _____

EYE SYMPTOMS

- Itching
- Redness
- Swelling
- Dryness

DURATION OF SYMPTOMS

- _____
- _____
- _____
- _____

MOUTH SYMPTOMS

- Burning
- Mass/Lesion
- Loss of Taste
- Dry Mouth

DURATION OF SYMPTOMS

- _____
- _____
- _____
- _____

NASAL SYMPTOMS

- Congestion Right Left
- Bleeding Right Left
- Nasal Mass Right Left
- Sneezing
- Itching
- Discharge
- Loss of Smell
- Snoring
- Post Nasal Drip
- Possible Allergies

DURATION OF SYMPTOMS

Right _____ Left _____

Right _____ Left _____

Right _____ Left _____

SINUS SYMPTOMS

- Headaches
 - Above eyes Right Left
 - Below eyes Right Left
 - Between eyes
- Pressure
- Recurrent Infections

DURATION OF SYMPTOMS

Right _____ Left _____

Right _____ Left _____

THROAT SYMPTOMS

- Hoarseness
- Frequent clearing of throat
- Recurrent infections
- Difficulty swallowing
- Lump sensation in throat
- Mass in throat
- Sore throat
- Itching

DURATION OF SYMPTOMS

NECK SYMPTOMS

- Masses
- Pain

DURATION OF SYMPTOMS

Patient's Signature:

Date:
