

Date of Visit: _____

Patient Name: _____

DOB: _____

Age: _____

Chart #: _____

Athena ID#: _____

SYSTEM REVIEW

Please circle response for each item below

CONSTITUTIONAL SYMPTOMS

Good general health lately..... No Yes
 Recent weight change..... No Yes
 Fever..... No Yes
 Fatigue..... No Yes
 Headaches..... No Yes

EYES

Eye disease or injury..... No Yes
 Wear glasses/contact lenses..... No Yes
 Blurred vision or double vision..... No Yes
 Glaucoma..... No Yes

EARS/NOSE/MOUTH/THROAT

Hearing loss or ringing..... No Yes
 Earaches or drainage..... No Yes
 Chronic sinus problem or rhinitis.. No Yes
 Nose bleeds..... No Yes
 Mouth sores..... No Yes
 Bleeding gums..... No Yes
 Bad breath or bad taste..... No Yes
 Sore throat or voice change..... No Yes

CARDIOVASCULAR

Heart trouble..... No Yes
 Chest pain or angina..... No Yes
 Palpitation..... No Yes
 Shortness or breath with walking or lying flat..... No Yes
 Swelling of feet, ankles or hands.. No Yes

RESPIRATORY

Sleep Apnea..... No Yes
 Chronic or frequent coughs..... No Yes
 Spitting up blood..... No Yes
 Shortness of breath..... No Yes
 Asthma or wheezing..... No Yes

GASTROINTESTINAL

Loss of appetite..... No Yes
 Change in bowel movements or constipation..... No Yes
 Nausea or vomiting..... No Yes
 Frequent diarrhea..... No Yes
 Painful bowel movements or constipation..... No Yes
 Rectal bleeding/Blood in stool..... No Yes
 Abdominal pain or heartburn..... No Yes
 Peptic ulcer (stomach or duodenal) No Yes

MUSCULOSKELETAL

Joint Pain..... No Yes
 Joint Stiffness or swelling..... No Yes
 Muscle pain or cramps..... No Yes
 Back pain..... No Yes
 Cold extremities..... No Yes
 Difficulty in walking..... No Yes

INTEGUMENTARY (skin, breast)

Rash or itching..... No Yes
 Change in skin color..... No Yes
 Change in hair or nails..... No Yes
 Varicose veins..... No Yes
 Breast pain..... No Yes
 Breast lump..... No Yes
 Breast discharge..... No Yes

NEUROLOGICAL

Frequent or recurring headaches No Yes
 Light headed or dizzy..... No Yes
 Convulsions or seizures..... No Yes
 Numbness or tingling sensations. No Yes
 Tremors..... No Yes
 Paralysis..... No Yes
 Stroke..... No Yes
 Head injury..... No Yes

PSYCHIATRIC

Memory loss or confusion..... No Yes
 Nervousness..... No Yes
 Depression..... No Yes
 Insomnia..... No Yes

ENDOCRINE

Glandular or hormone problem.... No Yes
 Thyroid disease..... No Yes
 Diabetes..... No Yes
 Excessive thirst or urination..... No Yes
 Heat or cold intolerance..... No Yes
 Skin becoming dryer..... No Yes
 Change in hat or glove size..... No Yes

HEMATOLOGICAL/LYMPHATIC

Slow to heal after cuts..... No Yes
 Bleeding or bruising tendency..... No Yes
 Anemia..... No Yes
 Phlebitis..... No Yes
 Past transfusion..... No Yes
 Enlarged glands..... No Yes

PLEASE COMPLETE PAGE 2

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CONTINUED FROM PREVIOUS PAGE

Please circle response for each item below

GENITOURINARY

Burning or painful urination..... No Yes
 Blood in urine..... No Yes
 Change in force of strain
 when urinating..... No Yes
 Incontinence or dribbling..... No Yes
 Kidney stones..... No Yes
 Sexual difficulty..... No Yes
 Male-testicle pain..... No Yes
 Female-pain w/periods..... No Yes
 Female-irregular periods..... No Yes
 Female-vaginal discharge..... No Yes
 Female-# pregnancies _____ # miscarriages _____
 Female-date of last pap smear _____

ALLERGIC/IMMUNOLOGIC

History of skin reaction or other adverse
 reaction to:
 Penicillin or other antibiotics..... No Yes
 Morphine, Demerol, or other
 Novocaine or other anesthetics... No Yes
 Aspirin or other pain remedies.... No Yes
 Tetanus antitoxin or other
 serums..... No Yes
 Iodine, methiolate or other
 antiseptic..... No Yes
 Other drugs/medications _____
 Known food allergies _____

PATIENT'S SIGNATURE _____ **DATE** _____