INITIAL REVIEW of SYSTEM

Patient Name: (print)_____ Today's Date: ____/____/____

Reason for visit: _____

Constitutional Symptoms

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

Cardiovascular

Heart trouble/murmurs	No	Yes
Chest pain or angina pectoris	No	Yes
High blood pressure	No	Yes
Shortness of breath	No	Yes

Respiratory

Chronic or frequent coughs	No	Yes
Spitting up blood	No	Yes
Shortness of breath	No	Yes
Asthma or wheezing	No	Yes
Chronic Lung Conditions	No	Yes

Gastrointestinal

Loss of appetite	No	Yes
Change in bowel movements	No	Yes
Nausea of vorniting	No	Yes
Frequent diarrhea	No	Yes
Rectal bleeding or 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
Weakness of muscles or joints	No	Yes
Muscle pain or cramps	No	Yes
Back pain	No	Yes
Cold extremities	No	Yes
Pain in walking	No	Yes

Integumentary

Rash or lichting	No	Yes
Change in skin color	No	Yes
Change in hair or nails	No	Yes
Varicose veins	No	Yes
Leg ulcers	No	Yes

Neurological

Frequent or recurring headache	No	Yes
Light headed or dizzy	No	Yes
Convulsion or seizures	No	Yes
Numbers or tingling sensations	No	Yes
Tremors	No	Yes
Paralysis	No	Yes
Stroke	No	Yes
Head injury	No	Yes

Endocrine

Glandular or hormone problem	No	Yes
Thyroid disease	No	Yes
Diabetes	No	Yes
Do you take Glucophage	No	Yes
Excessive thirst or urination	No	Yes
Heart or cold in tolerance	No	Yes
Skin becoming dryer	No	Yes

Hematologic/Lymphatic

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

Allergic/Immunologic

History of skin reaction or other adverse reaction to:		
Penicillin or other antibiotics	No	Yes
Iodine, methiolate or other antiseptic	No	Yes
Other drugs/medication allergies	No	Yes
If yes, please list		
Do you take coumadin, aspirin or other	No	Yes
Do you smoke?	No	Yes
How much?		
Do you drink?	No	Yes
How much?		

Family History

Father alive deceased age (when deceased) cause

Mother alive deceased age(when deceased) cause

Siblings alive deceased age(when deceased) cause

Do any members of your family have(please check those that apply):

1. Leg Ulcers 2. Aortic Aneurysm

3.Varicose Veins 4. Arterial

Past Surgeries: (Please state type of surgery and approximate date of surgery)

Medications

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Patient signature Physician signature Date: