

Name: _____

Date: _____

Evaluation & Management

Avtar Robert Moore, D.O.

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SYSTEM REVIEW:

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 lens.....	No	Yes
Blurred 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 problems 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
Swollen glands in neck.....	No	Yes

CARDIOVASCULAR

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

RESPIRATORY

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	No	Yes
Nausea or vomiting	No	Yes
Frequent diarrhea	No	Yes
Painful bowel movements/constipation .	No	Yes
Rectal bleeding or blood in stool	No	Yes
Abdominal pain or heartburn	No	Yes
Peptic ulcer (stomach or duodenal	No	Yes

GENITOURINARY

Frequent urination	No	Yes
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 with periods	No	Yes
Female – irregular periods	No	Yes
Female – vaginal discharge	No	Yes
Female – # pregnancies _____ # miscarriages _____		
Female – date of last pap smear _____		
Female_ date of last mammogram _____		

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
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 sensation	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 problems	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

HEMATOLOGIC/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

ALLERGIC/IMMUNOLOGIC

History of skin reaction or other adverse reaction to:

Penicillin or other antibiotics	No	Yes
Morphine, Demerol, other narcotics .	No	Yes
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 _____