Nurturing Optimal Wellness

Nancy Russell, MD
5140 N. Antioch Road, Kansas City, MO 64119
(816) 453-5545

REVIEW OF SYSTEMS

Name ____ Date _________________

*****ON EACH OF THE FOLLOWING QUESTIONS – IF YOUR ANSWER IS "YES" PLEASE MARK A "C" FOR CURRENT SYMPTOMS OR CONDITIONS AND A "P" FOR PAST ONES.*****

HAVE YOU EVER HAD	YES	NO
Chronic Headaches		
Problems with vision		
Glaucoma or Cataracts		
Decreased hearing		
Nose bleeds		
Sinus trouble		
Hoarseness		
Trouble swallowing		
Teeth or gum problems		
Dry cough		
Productive cough		
Lung disease – asthma, bronchitis or emphysema		
Chest pain with exercise		
Enlarged heart or heart failure		
Ankle swelling		
Heart palpitations		
High cholesterol or triglycerides		
High blood pressure		
Heart attack		
Change in bowel habits		
Constipation		
Diarrhea or blood in stool		
Indigestion, heartburn or gas		
Yellow jaundice or hepatitis		
Ulcers (stomach or duodenal)		
Hiatal hernia		
Gall stones		
Hemorrhoids		
Stomach x-ray (upper GI)		
Colon x-ray (lower GI)		
Colonoscopy or Procto		
Infections of kidneys or bladder		
Blood or protein in urine		
Kidney stones		
Trouble starting or holding urine		

HAVE YOU EVER HAD	YES	NO
Kidney x-rays (IVP)		
Problems with sexual desire or function		
Low Back pain		
Disc trouble		
Joint trouble		
Phlebitis or blood clots		
Leg pain with exercise		
Osteoporosis		
Unconsciousness from head injury		
Paralysis or stroke		
Dizziness (lightheadedness)		
Dizziness (room spins around)		
Convulsions or epilepsy		
Under active or overactive thyroid		
Thyroid goiter, nodule or tumor		
Hypoglycemia (low blood sugar)		
Diabetes Mellitus		
Skin cancers		
Cancer or blood disorder		
Chronic skin disease or rash		
Are you frequently ill?		
Do you have difficulty falling asleep or staying asleep?		
Are you considered a nervous person?		
Are you easily upset or irritated?		
Do you often cry?		
Do you feel unhappy or depressed?		

Please continue on the back of this page

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REVIEW OF SYSTEMS

WOMEN ONLY

	YES	NO
Breast lumps, tumors or discharge		
Hot flashes or vaginal dryness		
Surgery on your female organs		
Have you ever taken female hormones or birth control pills		

Age at beginning of menstruation
Age at end of menstruation
Irregular periods
Number of pregnancies
Number of miscarriages
Number of children born alive
Number of abortions
Last PAP smear date
Abnormal PAP smear
Last Mammogram (breast x-ray)
Birth Control Method

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PATIENT INFORMED CONSENT

I authorize any physician, provider or staff member of Nurturing Optimal Wellness to have access to any and all of my medical records for the purpose of my care. I authorize the free exchange of any medical information between any providers that I see at Nurturing Optimal Wellness for the enhancement of my care. I realize that this exchange may involve discussion of my physical, emotional, and mental status, both past and present. I also authorize the release of any medical information necessary to initiate or expedite the processing of any insurance claim for services provided by any Nurturing Optimal Wellness' physician or provider. I further authorize and request that payment for such claims be made directly to me unless Nurturing Optimal Wellness request that payment be made to them.

PERSON AS EMERGENCY CONTACT: ________________________________
(Name) (Relationship)
AT THE FOLLOWING NUMBERS: ____
(*Please Indicate Home/Work/Cell*)

NORMAL TEST OR LAB RESULTS AND/OR APPOINTMENT INFORMATION MAY BE:

Please check all that apply and fill in appropriate numbers.

____LEFT ON ANSWERING MACHINE/VOICE MAIL AT HOME # __________________

____LEFT ON MY CELL #____

____LEFT ON ANSWERING MACHINE/VOICE MAIL AT WORK#____________________

____DISCUSSED WITH: ____
(Name) (Relationship)
AT THE FOLLOWING NUMBERS: ____
(*Please Indicate Home/Work/Cell*)

____DISCUSSED WITH: ____
(Name) (Relationship)
AT THE FOLLOWING NUMBERS: ____
(*Please Indicate Home/Work/Cell*)

Patient's Printed Name: ____

Patient's Signature: ____ Date: _______________

Parent, Guardian, or Power of Attorney's Signature for Minor or Dependent

____ Date: ____________________________

Relationship to Patient: ____

Witness's Signature: ________________________________ Date: ____________________________

CURRENT MEDICATIONS

Supplements

(other side)

Patient Name: ____ Date:_________________________

Start Date	Medication	Dose, Quantity & Time of Day Taken		

Date	Allergy or Sensitivity	Reaction

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CURRENT SUPPLEMENTS

Medications

(other side)

Patient Name: ____ Date:_________________________

Start Date	Medication	Dose, Quantity & Time of Day Taken		

Date	Allergy or Sensitivity	Reaction

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