

Infectious Disease Associates Review of Systems

	Please Circle ALL Symptoms That Apply
Constitutional	Fever _____ Sweats Chills Recent Weight Gain / Loss Fatigue
Eyes	Blurred or Double Vision Eye Infections Light Sensitivity Visual Disturbances
Ears/Nose/Throat/Mouth	History of Ear Infections Vertigo Runny Nose Nasal Drainage Pain Over the Sinuses Sinus Infections Current or Past Lesions in Mouth Oral Herpes Infections History of Sore Throats Ear Pain
Cardiovascular	Chest Pain Heart Murmurs Coldness/Numbness in Extremities Edema Leg Pain while Walking
Respiratory	Asthma Shortness of Breath Chronic Cough Hemoptysis (coughing up blood) Sputum Production Bronchitis/Pneumonia Cough
Gastrointestinal	Indigestion Burning of the esophagus Nausea Vomiting Liver Disease Jaundice Diarrhea Constipation Abdominal Pain
Genitourinary	Renal Calculi (kidney stones) Painful Urination Hesitancy starting a Stream Changes in urine Stream Incontinence Frequent Urination at Night
Musculoskeletal	Joint Aches/Pains Muscle Cramping Weakness Joint Swelling/Redness/Pain Joint Stiffness Chronic Back Pain
Integumentary (Skin)	Abnormal Mammogram Skin Lesions Rashes Lumps Known Skin Disease Itching Breast Tenderness/Swelling Redness
Neurological	Headaches Numbness Memory Loss Disorientation Inability to Concentrate Problems with Gait/Balance/coordination Sensory Disturbances
Psychiatric	Mental Illness Depression
Endocrine	Thyroid Disease Diabetes Heat/Cold Tolerance Changes in Hair Distribution Changes in Skin Pigmentation
Hematologic/Lymphatic	Easy Bruising Anemia Bleeding Tendencies Blood Transfusions History of Systemic Infections
Allergy/Immunologic	Allergies Eczema Hives Itching Allergic Reactions to Medications

Signature of Patient: _____

Date: _____

Print Name: _____

Date of Birth: _____

Infectious Disease Associates of Kansas City, P.C.
ACKNOWLEDGMENT OF
RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have received a copy of the Infectious Disease Associates of Kansas City, P.C.'s Notice of Privacy Practices. The Notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the Notice may be changed at any time and that I may obtain a revised copy of the Notice at Infectious Disease Associates of Kansas City, P.C., 6400 Prospect, Suite 392, Kansas City, MO.

SIGNATURE: _____ **DATE:** _____

If you are not the patient, please fill out the following information:

Name: _____

Relationship to Patient: _____

Address: _____

Telephone: _____

Please furnish a copy of any conservator/guardianship papers with this form.

INFECTIOUS DISEASE ASSOCIATES OF KANSAS CITY, PC

Thank you for being on time for your appointment. We strive to keep your wait time to a minimum and appreciate your cooperation.

If you should find that you will be more than 15 minutes late for an appointment please call us.

You may receive an automated appointment reminder call approximately 48 hours before your appointment. If you are unable to keep your appointment please call at least 24 hours in advance to reschedule. If you do not call and do not show for your scheduled appointment you may be charged a \$25.00 fee.