WOMEN'S
HEALTH CENTER
Obstetrics & Gynecology

REVIEW OF SYSTEMS

Name _____ Date _____

Are you currently experiencing any of the following symptoms? *Please check the appropriate box(es), if the answer is "yes"*

Constitutional:	**Gynecological:**
☐ Fever	☐ Bleeding or pain with intercourse
☐ Chills	☐ Unusual vaginal discharge or odor
☐ Sweats	☐ Vulvar or vaginal itching or burning
☐ Weight change - gain or loss	☐ Pelvic pain
☐ Weakness	
☐ Fatigue	**Urinary:**
	☐ Painful urination
Eyes:	☐ Frequent urination
☐ Change in vision	☐ Urinary urgency
	☐ Blood in urine
Ears, Nose, Mouth, Throat:	☐ Urinary incontinence
☐ Change in hearing	Getting up at night to urinate
☐ Nose bleeds	
☐ Sore throat	**Musculoskeletal:**
☐ Dry mouth	☐ Back pain
	☐ Weakness
Cardiovascular:	☐ Joint pain, stiffness, swelling
☐ Dizziness	
☐ Shortness of breath	**Integumentary / Breast:**
☐ Chest pain	☐ Nodules
☐ Loss of consciousness	☐ Change in moles, freckles
☐ Palpitations	☐ Change in hair - growth, loss, texture
	☐ Breast lumps
Respiratory:	☐ Breast nipple discharge
☐ Chest pain	☐ Breast pain
☐ Cough - productive or dry	
☐ Shortness of breath	**Neurological / Psychiatric:**
☐ Wheezing	☐ Memory change
	☐ Depression
Gastrointestinal:	☐ Anxiety
☐ Abdominal pain	☐ Mood swings
☐ Nausea, vomiting	☐ Numbness or tingling
☐ Change in bowel habits	
☐ Change in appetite	**Endocrine:**
☐ Dark or bloody stool	☐ Excessive thirst, urination
☐ Indigestion	☐ Tremor
☐ Constipation or diarrhea	☐ Cold or heat intolerance
	☐ Hot flashes
Hematologic / Lymphatic:	☐ Night sweats
☐ Swollen lymph glands	☐ Sleep disturbances
☐ Easy bruisability	

Thank you for taking the time to answer these questions. Most insurance companies now require this information to be updated at every visit.

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