My WOMEN'S CENTER
Gyn. Health. Beauty. Joy.

Name _____

Date _____

REVIEW OF SYSTEMS

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

Constitutional:
- ☐ Fever
- ☐ Chills
- ☐ Sweats
- ☐ Weight change - gain or loss
- ☐ Weakness
- ☐ Fatigue

Eyes:
- ☐ Change in vision

Ears, Nose, Mouth, Throat:
- ☐ Change in hearing
- ☐ Nose bleeds
- ☐ Sore throat
- ☐ Dry mouth

Cardiovascular:
- ☐ Dizziness
- ☐ Shortness of breath
- ☐ Chest pain
- ☐ Loss of consciousness
- ☐ Palpitations

Respiratory:
- ☐ Chest pain
- ☐ Cough - productive or dry
- ☐ Shortness of breath
- ☐ Wheezing

Gastrointestinal:
- ☐ Abdominal pain
- ☐ Nausea, vomiting
- ☐ Change in bowel habits
- ☐ Change in appetite
- ☐ Dark or bloody stool
- ☐ Indigestion
- ☐ Constipation or diarrhea
- ☐ Leak Stool

Hematologic / Lymphatic:
- ☐ Swollen lymph glands
- ☐ Easy bruisability

Gynecological:
- ☐ Bleeding or pain with intercourse
- ☐ Unusual vaginal discharge or odor
- ☐ Vulvar or vaginal itching or burning
- ☐ Pelvic pain

Urinary:
- ☐ Painful urination
- ☐ Frequent or urgent urination
- ☐ Difficulty emptying bladder
- ☐ Blood in urine
- ☐ Leak urine
- ☐ Getting up at night to urinate
- ☐ Trouble with kegal exercises

Musculoskeletal:
- ☐ Back pain
- ☐ Weakness
- ☐ Joint pain, stiffness, swelling

Integumentary / Breast:
- ☐ Nodules
- ☐ Change in moles, freckles
- ☐ Change in hair - growth, loss, texture
- ☐ Breast lumps
- ☐ Breast nipple discharge
- ☐ Breast pain

Neurological / Psychiatric:
- ☐ Memory change
- ☐ Depression
- ☐ Anxiety
- ☐ Mood swings
- ☐ Numbness or tingling

Endocrine:
- ☐ Excessive thirst, urination
- ☐ Tremor
- ☐ Cold or heat intolerance
- ☐ Hot flashes
- ☐ Night sweats
- ☐ Sleep disturbances

1. Do you have problems with your bladder? Yes ☐ No ☐
   For example:
   Do you leak urine?
   Do you experience the interruption of life or sleep patterns due to your bladder?
   Would you like more information on treatment of these issues?
2. Do you ever leak stool? Yes ☐ No ☐
   Are you interested in discussing this with your Doctor?
3. Are you interested in learning how to strengthen your pelvic floor muscles? Yes ☐ No ☐
4. Is there anything about the look or appearance of your vagina that bothers you? Yes ☐ No ☐
   Would you like more information about options to help you with this?

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