Patient: _____ Date: _____

Review of Systems

Do you now or have you had any problems related to the following systems? Circle Yes or No

General

Have you gained or lost weight recently?	Y	N
How many pounds?	___	
Other		

Integumentary

Skin rash	Y	N
Nipple discharge	Y	N
Persistent itch	Y	N
Rash	Y	N
Masses	Y	N
Pain in Breast	Y	N

Neurological

Trouble sleeping	Y	N
Headache	Y	N
Seizures	Y	N
Other		

Genitourinary

Urine retention	Y	N
Painful urination	Y	N
Frequent urination	Y	N
Blood In Urine	Y	N
Incomplete emptying on Urination	Y	N
Pain with Sex	Y	N
Chronic Pelvic Pain	Y	N
Bleeding with Sex	Y	N
Lack of Menses	Y	N
Bleeding in Between Menses	Y	N
Incontinence	Y	N
Hot Flushes	Y	N
Frequent Menses	Y	N
Irregular Menses	Y	N
Very Painful Menstruation	Y	N
Very Heavy Menstruation	Y	N
Vaginal Discharge/Odor	Y	N

Endocrine

Excessive thirst	Y	N
Too hot/cold	Y	N
Tired/sluggish	Y	N
Other		

Respiratory

Asthma	Y	N
Frequent cough	Y	N
Shortness of breath	Y	N
Other		

Gastrointestinal

Abdominal pain	Y	N
Nausea/vomiting	Y	N
Indigestion/heartburn	Y	N
Other		

Hematologic/Lymphatic

Swollen glands	Y	N
Blood clotting problem	Y	N
Anemia	Y	N

Cardiovascular

Chest pain	Y	N
Varicose veins	Y	N
High blood pressure	Y	N
Other		

Psychiatric

Are you unhappy with your life?	Y	N
Do you feel severely depressed?	Y	N
Have you considered suicide?	Y	N
Other		

Physician Reviewed: _____