

Patient Name: _____



Women's Pelvic Specialty Care
of New Mexico, LLC

Date of Birth: _____

PATIENT REVIEW OF SYSTEMS

Patient: Please check below if you have any of the following problems:		PROVIDER COMMENTS
SYSTEM		Document for all positive findings
1. General <input type="checkbox"/> No Problems	<input type="checkbox"/> Weight loss <input type="checkbox"/> Weight Gain # lbs _____ <input type="checkbox"/> Fatigue <input type="checkbox"/> Fever Other:	
2. Eyes <input type="checkbox"/> No Problems	<input type="checkbox"/> Glasses / Contact lenses <input type="checkbox"/> Vision changes Other:	
3. Head and Neck - Ears, Nose, Mouth, Throat <input type="checkbox"/> No Problems	<input type="checkbox"/> Headache <input type="checkbox"/> Stiffness <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Sinus infections <input type="checkbox"/> Mouth sores Other:	
4. Heart / Circulation <input type="checkbox"/> No Problems	<input type="checkbox"/> Difficulty breathing when lying down <input type="checkbox"/> Swelling in legs <input type="checkbox"/> Irregular heart rate <input type="checkbox"/> Chest pain Other:	
5. Lungs ? Breathing <input type="checkbox"/> No Problems	<input type="checkbox"/> Shortness of breath <input type="checkbox"/> Wheezing <input type="checkbox"/> Coughing up blood Other:	
6. Digestion / Bowels <input type="checkbox"/> No Problems	<input type="checkbox"/> Nausea / vomiting <input type="checkbox"/> Gas <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Bloody stools <input type="checkbox"/> Heartburn / reflux Other:	
7. Kidneys / Bladder <input type="checkbox"/> No Problems	<input type="checkbox"/> Blood in urine <input type="checkbox"/> Painful urination <input type="checkbox"/> Frequent Urination <input type="checkbox"/> Urgency <input type="checkbox"/> Incomplete emptying <input type="checkbox"/> Incontinence Other:	
8. Reproductive system <input type="checkbox"/> No Problems	<input type="checkbox"/> Pain with intercourse <input type="checkbox"/> Irregular or missed periods <input type="checkbox"/> Abdominal discomfort Other:	
9. Muscles / Bones <input type="checkbox"/> No Problems	<input type="checkbox"/> Muscle weakness <input type="checkbox"/> Arthritis <input type="checkbox"/> Back injury Other:	
10. Skin / Breasts <input type="checkbox"/> No Problems	<input type="checkbox"/> Rash <input type="checkbox"/> Itching <input type="checkbox"/> Breast pain <input type="checkbox"/> Discharge <input type="checkbox"/> Lump Other:	
11. Nervous System <input type="checkbox"/> No Problems	<input type="checkbox"/> Fainting <input type="checkbox"/> Seizures <input type="checkbox"/> Numbness <input type="checkbox"/> Problems Walking Other:	
12. Mental or Emotional <input type="checkbox"/> No Problems	<input type="checkbox"/> Anxiety <input type="checkbox"/> Crying <input type="checkbox"/> Depression <input type="checkbox"/> Insomnia Other:	
13. Endocrine <input type="checkbox"/> No Problems	<input type="checkbox"/> Diabetes - Type: _____ <input type="checkbox"/> Hot flashes <input type="checkbox"/> Low thyroid <input type="checkbox"/> Overactive thyroid Other:	
14. Blood / Lymphatic <input type="checkbox"/> No Problems	<input type="checkbox"/> Bruises <input type="checkbox"/> Clotting problems <input type="checkbox"/> Swollen lymph nodes Other:	
15. Allergies <input type="checkbox"/> None known		

Additional provider comments by system number:

Reviewed by - Provider: _____

Date ____ / ____ / ____