Patient Name: _____

Date of Birth: _____

Women's Pelvic Care

PATIENT REVIEW OF SYSTEMS

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

Additional provider comments by system number:

Reviewed by - Provider: _____ Date _____ / _____ / _____