WOMEN LIVING WELL
OBSTETRICS & GYNECOLOGY

REVIEW OF SYSTEMS – RETURN VISIT

*HAVE YOU HAD ANY PROBLEMS RELATED TO THE FOLLOWING SYMPTOMS IN THE **PAST MONTH**? CIRCLE YES OR NO*

Today's Date: _____ Name: _____ Date of Birth: _____

GENERAL			**GENITOURINARY**		
Fatigue	Y	N	Blood in Urine	Y	N
Fever / Chills	Y	N	Menstrual Irregularity	Y	N
Night Sweats	Y	N	Painful Menstrual Cycle	Y	N
Weight Gain	Y	N	Vaginal Discharge	Y	N
Weight Loss	Y	N	Vaginal Dryness	Y	N
EYES			Vaginal Itching	Y	N
Vision Changes	Y	N	Painful Sex	Y	N
EAR, NOSE, & THROAT			**SKIN**		
Hearing Loss	Y	N	Hair Loss	Y	N
Runny Nose	Y	N	New Skin Lesions	Y	N
Ringing in Ears	Y	N	Rash	Y	N
Sinus Problem	Y	N	Pigmentation Change	Y	N
Sore Throat	Y	N	**NEUROLOGIC**		
BREAST			Headache	Y	N
Breast Lump	Y	N	Muscular Weakness	Y	N
Tenderness	Y	N	Tingling or Numbness	Y	N
Nipple Discharge	Y	N	Memory Difficulties	Y	N
CARDIOVASCULAR			**MUSCULOSKELETAL**		
Chest Pain	Y	N	Back Pain	Y	N
Swelling in Legs	Y	N	Limitation of Motion	Y	N
Palpitations	Y	N	Joint Pain	Y	N
Fainting	Y	N	Muscle Pain	Y	N
Irregular Heart Beat	Y	N	**ENDOCRINE**		
RESPIRATORY			Cold Intolerance	Y	N
Cough	Y	N	Heat Intolerance	Y	N
Shortness of Breath	Y	N	Excessive Thirst	Y	N
Post Nasal Drip	Y	N	Excessive Amount of Urine	Y	N
Wheezing	Y	N	**PSYCHOLOGY**		
GASTROINTESTINAL			Difficulty Sleeping	Y	N
Abdominal Pain	Y	N	Depression	Y	N
Constipation	Y	N	Anxiety	Y	N
Diarrhea	Y	N	Suicidal Thoughts	Y	N
Hemorrhoids	Y	N	**HEMATOLOGIC / LYMPHATIC**		
Nausea	Y	N	Easy Bruising	Y	N
Vomiting	Y	N	Easy Bleeding	Y	N
GENITOURINARY			Swollen Lymph Glands	Y	N
Burning with Urination	Y	N	**ALLERGY / IMMUNOLOGY**		
Urinary Frequency	Y	N	Sinus Allergy Symptoms	Y	N
Urinary Urgency	Y	N	Hives	Y	N
Urinary Incontinence	Y	N	Frequent Illness	Y	N

Tobacco Use	Current	Previous	Never
Alcohol Use (drinks/day)	0 1 2 3 4 5+		
Drug Use	Yes	No	
Sexually Active	Yes	No	

Method of Contraception

None	Abstinence	Oral Contraceptive (Pill)
IUD	Condoms	Rhythm
Contraceptive Implant	Spermicide	Contraceptive Patch
Tubal Ligation	Vasectomy	Vaginal Ring
Diaphragm	Hysterectomy	Depo-provera

Start Date of Last Menstrual Period: _____

Medical History *Please list changes since your last visit	
Surgical History *Please list changes since your last visit	
Family Medical History *Please list changes since your last visit	

At any time, has your partner ever hit you, kicked you, or otherwise hurt you?	YES		NO	
Do you have sex with	Men	Women	Both	Neither

Over the last 2 weeks, how often have you been bothered by any of the following problems?

1. Little interest of pleasure in doing things:

Not at all	Several days	More than half the day	Nearly every day

2. Feeling down, depressed or hopeless:

Not at all	Several days	More than half the day	Nearly every day

Have you received you flu shot? Yes No

If yes, where did you receive it? _____