### Review of Systems Worksheet

Review of Systems (please mark if you are currently having problems with any of the below items):

#### Head/Eyes/Ears/Throat:
- [ ] Hearing Disorder
- [ ] Glaucoma
- [ ] Sinus Disorder
- [ ] Double Vision
- [ ] Ringing Ears
- [ ] Other: ____________
- [ ] Headaches
- [ ] Dizziness
- [ ] Double Vision
- [ ] Ringing Ears
- [ ] Other: ____________

#### Blood:
- [ ] Anemia
- [ ] Easy Bruising
- [ ] Sickle Cell
- [ ] Difficulty Clotting
- [ ] Thalassemia
- [ ] Other: ____________

#### Nodes/Glands:
- [ ] Swollen Glands
- [ ] Head/Cold Intolerance
- [ ] Excessive Thirst
- [ ] Excessive Urination

#### Breasts:
- [ ] Lumps
- [ ] Deformity
- [ ] Cysts
- [ ] Pain Prior to Menstruation
- [ ] Nipple Discharge
- [ ] Other: ____________

#### Gastrointestinal:
- [ ] Heartburn
- [ ] Blood in Stool
- [ ] Constipation
- [ ] Hemorrhoids
- [ ] Hepatitis
- [ ] Other: ____________
- [ ] Hernia
- [ ] Gall Bladder Disease

#### Cardiac:
- [ ] Chest Pain
- [ ] Heart Palpitations
- [ ] Shortness of Breath
- [ ] Other: ____________

#### Urinary:
- [ ] Kidney/Bladder Infection
- [ ] Kidney Stone
- [ ] Pain with Urination
- [ ] Increased Frequency of Urination
- [ ] Incontinence of Urine
- [ ] Other: ____________

#### Skeletal:
- [ ] Broken Bones
- [ ] Difficulty Walking
- [ ] Unexplained Back Pain
- [ ] Arthritis
- [ ] Other: ____________

#### Neurologic:
- [ ] Seizures
- [ ] Fainting Spells
- [ ] Memory Loss
- [ ] Migraine Headaches
- [ ] Other: ____________

#### Psychiatric:
- [ ] Depression
- [ ] Anxiety
- [ ] Premenstrual Tension

#### Gynecologic:
- Age of First Period: ____________
- Last Normal Menstrual Period: ____________
- Regular
- Irregular

- [ ] Heavy Periods
- [ ] Yes
- [ ] No
- [ ] If so, how many pads and/or tampons per day: ____________

- [ ] Prolonged Periods
- [ ] Yes
- [ ] No
- [ ] If so, how many days: ____________

- [ ] Painful Periods
- [ ] Yes
- [ ] No
- [ ] If so, which medications help: ____________

- [ ] Painful Intercourse
- [ ] Yes
- [ ] No

- [ ] Frequent Yeast
- [ ] Yes
- [ ] No

- [ ] Infections
- [ ] Yes
- [ ] No

- [ ] Abnormal Discharge
- [ ] Yes
- [ ] No

- [ ] # of pregnancies: ____________
- [ ] # of live births: ____________
- [ ] # of miscarriages/abortions: ____________
- [ ] # of tubal pregnancies: ____________

**Have you had:**
- Gonorrhea
- Yes
- No
- Syphilis
- Yes
- No
- Chlamydia
- Yes
- No
- Other: ____________

__________________________________________  ___________________________
Patient Signature                                           Date