

Name: _____

Date: _____

Women's' Health: # of pregnancies: _____ # of deliveries: _____
1st day of most recent period: _____ Frequency of Periods: _____
Length of Periods: _____ Birth control method: _____

Women's' Health: Do you have an concerns about your periods? _____

Do you have any concerns about menopause? _____

Review of Systems: Please check any current problems your have on the list below;

Constitutional

- ___ Fevers/chills/sweats
- ___ Unexplained weight loss/gain
- ___ Change in energy/weakness
- ___ Excessive thirst or urination

Eyes

- ___ Change in vision

Ears/Nose/Throat/Mouth

- ___ Difficulty hearing/ringing ears
- ___ Problems with teeth or gums
- ___ Hay fever/Allergies
- ___ Sore throat
- ___ Difficulties swallowing
- ___ Nose bleeds
- ___ Sinus trouble

Cardiovascular

- ___ Chest pain/discomfort
- ___ Palpitations
- ___ Murmur
- ___ Swollen ankles
- ___ High blood pressure

Breast

- ___ Lump/nipple discharge

Respiratory

- ___ Cough/wheeze
- ___ Difficulty breathing
- ___ Tuberculosis

Gastrointestinal

- ___ Abdominal pain
- ___ Blood in stool
- ___ Constipation
- ___ Diarrhea
- ___ Nausea
- ___ Heartburn
- ___ Ulcers
- ___ Vomiting
- ___ Hepatitis

Genitourinary

- ___ Nighttime urination
- ___ Leaking urine
- ___ Blood in urine
- ___ Kidney problems
- ___ Pain w/urination
- ___ vaginal/penis discharge

Skin

- ___ Rash
- ___ Mole change
- ___ Hives

Muscles and Bones

- ___ Back pain
- ___ Muscle pain
- ___ Joint pain

Neurological

- ___ Headaches
- ___ Dizziness
- ___ Numbness
- ___ Memory Loss
- ___ Loss of Coordination

Psychiatric

- ___ Anxiety/Stress
- ___ Sleep problems
- ___ Depression
- ___ Concentration problems

Blood/Lymph

- ___ Lumps
- ___ Bruising/Bleeding
- ___ Cancer
- ___ Anemia/Iron deficiency

Sexual

- ___ impotence
- ___ STDs
- ___ Pain with intercourse
- ___ Infertility

Provider's initials: _____