



**REVIEW OF SYSTEMS (For all New Patients and for Established Patients' Annual Exam)**

**ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING SYMPTOMS?**

1. Constitutional:	<input type="checkbox"/> None	<input type="checkbox"/> Change in weight	<input type="checkbox"/> Fever	<input type="checkbox"/> Fatigue		
2. Eyes:	<input type="checkbox"/> None	<input type="checkbox"/> Vision change	<input type="checkbox"/> Glasses/contacts			
3. Ears, Nose, Throat & Mouth:	<input type="checkbox"/> None	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Sinus drainage or infection	<input type="checkbox"/> Ringing in Ears	<input type="checkbox"/> headaches	
4. Cardiovascular:	<input type="checkbox"/> None	<input type="checkbox"/> Shortness of breath lying down	<input type="checkbox"/> Chest pain	<input type="checkbox"/> Shortness of breath on exertion	<input type="checkbox"/> swelling	<input type="checkbox"/> Palpitations or irreg heart beat
5. Respiratory:	<input type="checkbox"/> None	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Coughing up blood	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Cough	
6. Gastrointestinal:	<input type="checkbox"/> None	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Bloody stool	<input type="checkbox"/> Nausea/vomiting	<input type="checkbox"/> Constipation	<input type="checkbox"/> Pain
7. Genitourinary:	<input type="checkbox"/> None	<input type="checkbox"/> Blood in urine <input type="checkbox"/> urinary incontinence	<input type="checkbox"/> Burning with urination <input type="checkbox"/> Abnormal bleeding	<input type="checkbox"/> Urinary Urgency <input type="checkbox"/> Pain with intercourse	<input type="checkbox"/> Incomplete Urinary Emptying <input type="checkbox"/> Menstrual cramps	<input type="checkbox"/> abnormal vaginal discharge
8. Musculoskeletal:	<input type="checkbox"/> None	<input type="checkbox"/> Muscle Weakness	<input type="checkbox"/> Muscle or joint pain			
9. Skin / breast:	<input type="checkbox"/> None	<input type="checkbox"/> Breast tenderness	<input type="checkbox"/> Nipple discharge	<input type="checkbox"/> Breast mass	<input type="checkbox"/> Rash	<input type="checkbox"/> Pigmented skin lesions
10. Neurological:	<input type="checkbox"/> None	<input type="checkbox"/> Fainting	<input type="checkbox"/> Seizures	<input type="checkbox"/> Numbness	<input type="checkbox"/> Severe memory problems	
11. Psychiatric:	<input type="checkbox"/> None	<input type="checkbox"/> Depression	<input type="checkbox"/> Crying	<input type="checkbox"/> Severe anxiety		
12. Endocrine:	<input type="checkbox"/> None	<input type="checkbox"/> Excessive hunger, thirst, or urination		<input type="checkbox"/> Hot Flashes	<input type="checkbox"/> Hair loss	<input type="checkbox"/> Heat/cold intolerance
13. Hematological/ Lymphatic:	<input type="checkbox"/> None	<input type="checkbox"/> Bruises easily	<input type="checkbox"/> Bleeds easily	<input type="checkbox"/> Swollen Lymph Glands	<input type="checkbox"/> blood clotting disorders, family or personal history	
14. Allergies: (see other side of page)						

**YOUR SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

*Thank you for your time and patience!*

**Women Partners In Health**

**PATIENT HISTORY**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Age: \_\_\_\_\_ y.o. Current home phone #: \_\_\_\_\_ Current work/cell#: \_\_\_\_\_

*Thank you for taking the time to answer these questions. Most insurance companies now require this information to be updated at every visit.*

1. Who is your primary care physician? \_\_\_\_\_  
Other physicians you see? \_\_\_\_\_

2. Are you here today for an Annual Exam? \_\_\_\_\_ Or for a problem? \_\_\_\_\_  
Procedure? \_\_\_\_\_ Repeat Pap \_\_\_\_\_

3. Please list all current medications ( name / dose / frequency): or  I'm not on any medication  
\_\_\_\_\_  
\_\_\_\_\_

If needed, what is your current form of birth control? \_\_\_\_\_

4. What year (if any) was your last Pap smear done in? \_\_\_\_\_ Mammogram? \_\_\_\_\_  
Cholesterol Screening? \_\_\_\_\_ result: \_\_\_\_\_  
Colorectal screening? \_\_\_\_\_ Bone Density? \_\_\_\_\_

What was the first day of your last menstrual period? \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

5. Are you allergic to any medications?  No Known Drug Allergies

YES- Medication(s) and reaction(s):  
\_\_\_\_\_  
\_\_\_\_\_

*New Patients should omit the questions in the area below. Sign your name at the bottom of this page, then turn to the backside of this page and complete the Review of Systems.*

**For Established Patients Only**  
*(You are an established patient if you have seen a physician in this office within the last three (3) years.)*

**Have you had any serious illnesses, operations, injuries, or have you been hospitalized since your last visit in this office?**  
 No  Yes- explain: \_\_\_\_\_  
**Have you discovered any additional information about your family history that we should know?**  
 No  Yes- explain: \_\_\_\_\_  
**Do you smoke, drink, or use street drugs?**  
 No  Yes- explain: \_\_\_\_\_  
**Has your marital status or occupation changed since your last visit?**  
 No  Yes- explain: \_\_\_\_\_

*If you are here for your Annual Exam, sign your name on the line below, then turn to the backside of this form and complete the Review of Systems. If you are here for another reason (not your Annual Exam) just sign your name below; you are DONE.*

ALL PATIENTS: Your Signature \_\_\_\_\_ Date: \_\_\_\_\_