WOMEN LIVING WELL
OBSTETRICS & GYNECOLOGY

RETURN REVIEW OF SYSTEMS

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	Burning with Urination	Y	N
Fever/Chills	Y	N	Urinary Frequency	Y	N
Night Sweats	Y	N	Urinary Incontinence	Y	N
Weight Gain	Y	N	Blood in Urine	Y	N
Weight Loss	Y	N	Menstrual Irregularity	Y	N
EYES			Painful Menstrual Cycle	Y	N
Vision Changes	Y	N	Painful Sex	Y	N
EAR, NOSE, & THROAT			Vaginal Discharge	Y	N
Hearing Loss	Y	N	Vaginal Dryness	Y	N
Runny Nose	Y	N	Vaginal Itching	Y	N
Ear Pain	Y	N	NEUROLOGIC		
Sinus Problem	Y	N	Headache	Y	N
Sore Throat	Y	N	Dizziness	Y	N
RESPIRATORY			Tingling or Numbness	Y	N
Cough	Y	N	Memory Difficulties	Y	N
Shortness of Breath	Y	N	MUSCULOSKELETAL		
Wheezing	Y	N	Back Pain	Y	N
CARDIOVASCULAR			Muscle Weakness	Y	N
Chest Pain	Y	N	Joint Pain	Y	N
Leg Swelling	Y	N	Joint Swelling	Y	N
Palpitations/Irregular Heartbeat	Y	N	ENDOCRINE		
GASTROINTESTINAL			Cold Intolerance	Y	N
Abdominal Pain	Y	N	Heat Intolerance	Y	N
Blood in Stools	Y	N	Excessive Thirst	Y	N
Constipation	Y	N	Excessive Amount of Urine	Y	N
Diarrhea	Y	N	PSYCHOLOGY		
Heartburn	Y	N	Difficulty Sleeping	Y	N
Loss of Appetite	Y	N	Anxiety	Y	N
Nausea	Y	N	Depression	Y	N
Vomiting	Y	N	Suicidal Thoughts	Y	N
BREAST			HEMATOLOGIC/LYMPHATIC		
Breast Lump	Y	N	Easy Bleeding	Y	N
Tenderness	Y	N	Easy Bruising	Y	N
Nipple Discharge	Y	N	Swollen Lymph Glands	Y	N
SKIN			ALLERY/IMMUNOLOGY		
Hair Loss	Y	N	Hives	Y	N
Rash	Y	N	Seasonal Allergies	Y	N
New Skin Lesions	Y	N	Environmental Allergies	Y	N

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

What pronouns do you use? She/Her He/His They/Them

I am: Heterosexual Homosexual Bisexual Non-Binary

Are you having sex?	Yes		No	
Do you have sex with	Men	Women	All	Neither
Any new partners since last visit?	Yes		No	
At any time, has your partner ever hit you, kicked you, or otherwise hurt you?	Yes		No	

METHOD OF CONTRACEPTION		
None/Other	Condoms	Oral Contraceptive (pill)
IUD/Implant	Vasectomy	Tubal Ligation
Depo Provera	Rhythm/Natural Family Planning	Withdrawal

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	

Tobacco Use	Current		Previous		Never	
Alcohol Use (drinks/day)	0	1	2	3	4	5+
Drug Use	Yes		No			
Exercise	Type:		How often?			

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

1. Little interest or 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