Washington Women's Health Specialists

Part of Washington Township Medical Foundation

Name: _____ Date of Birth: _____

Last Menstrual Period (if applicable) _____

REVIEW OF SYSTEMS

Please place a check mark beside any of the following symptoms if you have experienced them recently or have concerns about them. Your doctor will discuss any positive responses with you.

GENERAL
- ☐ Appetite Change
- ☐ Chills
- ☐ Fatigue
- ☐ Fever
- ☐ Hot Flashes Night Sweats
- ☐ Unexpected Weight Change

BREAST
- ☐ Lumps
- ☐ Nipple Discharge
- ☐ Tenderness

GYNECOLOGIC/ URINARY
- ☐ Abnormal bleeding
- ☐ Painful periods
- ☐ Pain with intercourse
- ☐ Burning with urination
- ☐ Flank pain
- ☐ Urinary frequency
- ☐ Genital sores
- ☐ Blood in urine
- ☐ Urinary incontinence
- ☐ Menstrual problem
- ☐ Pelvic pain
- ☐ Vaginal discharge
- ☐ Vaginal itching
- ☐ Vaginal pain

GI
- ☐ Distension
- ☐ Abdominal Pain
- ☐ Blood in stool
- ☐ Constipation
- ☐ Nausea
- ☐ Diarrhea
- ☐ Rectal Pain
- ☐ Diarrhea

ENDOCRINE
- ☐ Cold Intolerance
- ☐ Heat intolerance

PSYCHIATRIC
- ☐ Anxiety
- ☐ Difficulty concentrating
- ☐ Feeling depressed/sad
- ☐ Memory Loss
- ☐ Feeling nervous/anxious
- ☐ Sleep Problems

Please list any other areas of concern for you today: _____

_____

List any changes in your medical history or any surgeries in the last year.

_____
_____
_____
_____

Please list your current medications

_____
_____
_____
_____