Cheyenne OB&GYN
Kindness. Compassion. Experience you can trust.

Review of Systems

Please mark yes(circle, check or X) for any current symptoms you may have.

CONSTITUTIONAL

Symptom		
Weight gain	YES	NO
Weight loss	YES	NO
Fatigue	YES	NO
Hot flashes	YES	NO
Night sweats	YES	NO

EYES

Symptom		
Double vision	YES	NO
Blurred vision	YES	NO

HENT

Symptom		
Sore throat	YES	NO
Headaches	YES	NO
Nasal congestion	YES	NO
Ringing in ears	YES	NO
Sinus problems	YES	NO
Dental problems	YES	NO

BREAST

Symptom		
Lumps	YES	NO
Tenderness	YES	NO
Swelling	YES	NO
Redness	YES	NO
Nipple discharge	YES	NO

CARDIOVASCULAR

Symptom		
Chest pain	YES	NO
Irregular heart beats	YES	NO
Leg swelling	YES	NO
Rapid heart rate	YES	NO
DVT	YES	NO
Shortness of breath on exertion	YES	NO

RESPIRATORY

Symptom		
Shortness of breath	YES	NO
Chronic cough	YES	NO
Wheezing	YES	NO
Pain with deep breathing	YES	NO

NEUROLOGIC

Symptom		
	YES	NO
Dizziness	YES	NO
Seizures	YES	NO
Memory loss	YES	NO
Numbness	YES	NO

GASTROINTESTINAL

Symptom		
Nausea	YES	NO
Vomitting	YES	NO
Constipation	YES	NO
Diarrhea	YES	NO
Blood in stools	YES	NO
Heartburn	YES	NO

GENITOURINARY

Symptom		
Urgency	YES	NO
Frequency	YES	NO
Painful urination	YES	NO
Blood in urine	YES	NO
Nocturia	YES	NO
Incontinence	YES	NO
Heavy periods	YES	NO
Irregular periods	YES	NO
Painful periods	YES	NO
Painful intercourse	YES	NO
Bleeding with intercourse	YES	NO
Significant PMS	YES	NO
Decreased libido	YES	NO

INTEGUMENT

Symptom		
Rash	YES	NO
Itching	YES	NO
Abnormal hair growth	YES	NO

MUSCULOSKELETAL

Symptom		
Muscle pain	YES	NO
Joint pain	YES	NO
Muscular weakness	YES	NO

ENDOCRINE

Symptom		
Abnormal thirst	YES	NO
Loss of hair	YES	NO
Cold intolerance	YES	NO
Heat intolerance	YES	NO

PSYCHIATRIC

Symptom		
Anxiety	YES	NO
Stress	YES	NO
Depression	YES	NO
Suicidal ideation	YES	NO

HEME-LYMPH

Symptom		
Easy bruising	YES	NO
Easy bleeding	YES	NO
Enlarged lymph node	YES	NO
Lightheadedness	YES	NO
Blood clotting abnormality	YES	NO

ALLERIC-IMMUNOLOGIC

Symptom		
Seasonal allergies	YES	NO
Allergic dermatitis	YES	NO

The above information is accurate to the best of my knowledge.

_______________________________________ Patient Signature

_______________ Date

_______________________________________ Patient Name (Print)

_______________ DOB