Review of Systems

Patient: ____ Date: _______________________________

Have you been diagnosed with any new medical problems, or worsening existing problems? ___________________

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Have you had any surgeries, procedures or pregnancies since your last visit? _________________________________

Are you taking any new medicines? ____

Is there anything new in your family history? ____

Do you <u>currently</u> have problems related to the following systems? Circle Yes or No

General

Have you had fever, chills or sweats?	Y	N
Have you gained or lost weight recently?	Y	N
How many pounds? _________________	Y	N
Other ____		

Eyes

Blurred vision	Y	N
Double vision	Y	N
Have you ever lost vision?	Y	N
Other ____		

Allergic/Immunologic

Hay Fever	Y	N
Drug Allergies	Y	N
Infections	Y	N
Other ____		

Neurological

Seizures	Y	N
Trouble sleeping	Y	N
Headaches	Y	N
Other ____		

Endocrine

Excessive thirst	Y	N
Too hot/cold	Y	N
Tired/sluggish	Y	N
Other ____		

Gastrointestinal

Adbominal pain	Y	N
Nausea/vomiting	Y	N
Diarrhea	Y	N
Other ____		

Cardiovadcular

Chest pain	Y	N
Palpitations	Y	N
High blood pressure	Y	N
Other ____		

Ear/ Nose/ Mouth

Ear pain	Y	N
Sore throat/hoarse	Y	N
Sinus problem	Y	N
Other _______________________________________		

Genitourinary

Blood in the urine	Y	N
Painful/Frequent Urination	Y	N
Irregular menstruation	Y	N
Vaginal discharge/itching	Y	N
Pain during/after sex	Y	N
Other _______________________________________		

Respiratory

Asthma	Y	N
Frequent cough	Y	N
Shortness of breath	Y	N
Other _______________________________________		

Hematologic/Lymphatic

Anemia	Y	N
Swollen glands	Y	N
Blood clotting problem	Y	N
Other _______________________________________		

Psychiatric

Are you unhappy with your life?	Y	N
Do you feel severely depressed?	Y	N
Have you considered suicide?	Y	N
Do you feel safe at home?	Y	N

Musculoskeletal

Joint pain	Y	N
Swelling in your joints	Y	N
Arthritis	Y	N
Othe____		

Integumentary

Skin rash	Y	N
Nipple discharge	Y	N
Persistent itch	Y	N

Please review and sign where appropriate: It is the responsibility of the patient to call the lab or check portal in 2 weeks for your NORMAL pap smear results. If your pap smear is ABNORMAL you will be contacted by phone, or if we cannot reach you, by mail or email. Please make sure your address, email and telephone number is correct and updated in our records.

Sexually transmitted Infections: It is recommended to test all women 25 and under for chlamydia and gonorrhea. Over the age of 25, we recommend testing if you have any risk factors. Testing is done at the time of your pap smear. Most but not all, insurances cover this important test. Like any other test, if the lab received an insurance denial for these tests, you are responsible for payment to the lab

☐ I request chlamydia and gonorrhea testing at this time **☐ I decline chlamydia and gonorrhea testing at this time**

Patient signature: ___________________________________ Physician Reviewed: ______________________________