Name _____ Date of Birth _____

Review of systems (circle all that apply to you):

Vision problems	Chest discomfort	Skin growths	Excessive thirst
Hearing problems	Short of breath	Frequent urination	Weakness
Sinus trouble	Hypertension	Urine incontinence	Pain
Hay fever	Diabetes	Blood in urine	Fatigue
Nose bleeds	High cholesterol	History of STD(s)	Fever
Sore throat	Lumps in breast	HIV/AIDS	Chills
Hoarseness	Breast discharge	Anemia	Excess sweating
Lumps in neck	Trouble swallowing	Easy bruising	Fainting
Tooth problems	Nausea	Pain in legs	Seizures
Cough	Vomiting	Varicose veins	Tremors
Coughing up blood	Abdominal pain	Joint pain/stiffness	Headaches
Wheezing	Hepatitis	Blood clot leg	Numbness
Asthma	Jaundice	Lung blood clot	Tingling
COPD	Gallstones	Weight loss	Anxiety
Emphysema	Diarrhea	Weight gain	Depression
Bronchitis	Constipation	Heat intolerance	Trouble sleeping
TB exposure	Blood in stool	Cold intolerance	Appendicitis
Chest pain	Skin cancer	Excessive hunger	

Premenopausal women:

Last menstrual period _____ Periods are: regular: every ____ days irregular

Are you on birth control? Yes No Type: _____

Perimenopausal and postmenopausal women:

Last menstrual period _____ Any vaginal bleeding? _____

Any postmenopausal symptoms? _____

All women:

Number of pregnancies ____ Number of live births ____ Number of abortions/miscarriages ____

List all previous types of birth control used and for how long: _____
_____
_____

Painful intercourse? Yes No Pelvic pain? Yes No

Have you ever had an abnormal Pap/HPV test? Yes No Abnormal mammogram? Yes No