REVIEW OF SYSTEMS – FEMALE
DATE________________________

NAME: ______________________________ DATE OF BIRTH_______________________

DATE OF LAST EYE EXAM: __________________________________
DATE OF LAST DENTAL EXAM: ______________________________
DATE OF LAST TETANUS VACCINE: ___________________________
HAVE YOU HADA PNEUMOVAX: ____________________WHEN:_______________
DATE OF LAST MAMMOGRAM: _______________________________
DATE OF LAST PAP SMEAR: __________________________________
WHAT WAS YOUR LAST CHOLESTEROL: __________________WHEN:___________
DO YOU HAVE A LIVING WILL: ________________________________?

Have you had:	any unusual weight loss?	YES	NO
	any unusual fatigue?	YES	NO
	Persistent fever?	YES	NO
	Have you had blurred vision?	YES	NO
	Do you wear glasses/contact lenses?	YES	NO
	Have you had eye pain, redness or excessive tearing?	YES	NO
	Do you have glaucoma?	YES	NO
	Do you have cataracts?	YES	NO
	Have you had eye surgery?	YES	NO
Do you have:	hearing trouble?	YES	NO
	ringing in your ears?	YES	NO
	hay fever?	YES	NO
	bleeding gums?	YES	NO
	persistent hoarseness?	YES	NO
Do you have:	breast lumps or discharge?	YES	NO
	persistent rashes?	YES	NO
	Do you do home breast exams?	YES	NO
Do you have:	heart trouble?	YES	NO
	high blood pressure?	YES	NO
	shortness of breath when you lay down?	YES	NO
	swelling in your extremities?	YES	NO
	chest pain?	YES	NO
	palpitations?	YES	NO
	leg pain with prolonged walking?	YES	NO
	Have you had an EKG or heart tests?	YES	NO
	Have you had rheumatic fever?	YES	NO

(CONTINUED ON BACK)

Do you have:	trouble swallowing?	YES	NO
	heartburn?	YES	NO
	blood in your bowel movements or black, tarry bowel movements?	YES	NO
	constipation or diarrhea?	YES	NO
	abdominal pain?	YES	NO
	Have you had hepatitis or jaundice?	YES	NO
	Do you vomit blood?	YES	NO
	Have you had a change in bowel habits?	YES	NO
Do you have:	Have you ever been sexually active?	YES	NO
	Any sexual difficulties?	YES	NO
	Burning on urination?	YES	NO
	Blood in your urine?	YES	NO
	Have you had sexually transmitted diseases?	YES	NO
	Have you had unusual vaginal bleeding?	YES	NO
Do you have:	any joint pains or stiffness?	YES	NO
	arthritis?	YES	NO
	gout?	YES	NO
	backache?	YES	NO
Do you have:	seizures?	YES	NO
	paralysis?	YES	NO
	any numbness or tingling?	YES	NO
	tremors?	YES	NO
	memory loss or trouble with memory?	YES	NO
Do you have:	nervousness or tension?	YES	NO
	depression?	YES	NO
	alcohol or drug dependency?	YES	NO
	tobacco/nicotine dependency?	YES	NO
	trouble sleeping?	YES	NO
Do you have:	thyroid trouble?	YES	NO
	diabetes mellitus?	YES	NO
	excessive thirst?	YES	NO
	excessive hunger?	YES	NO
	excessive urination?	YES	NO
Have you had:	anemia?	YES	NO
	easy bruising or bleeding?	YES	NO
	a blood transfusion?	YES	NO
	swollen glands?	YES	NO
Have you had:	any allergies?	YES	NO
	Problems with recurrent infections?	YES	NO