DUNWOODY OBSTETRICS & GYNECOLOGY, P.C.
REVIEW OF SYSTEMS WORKSHEET

Review of Systems (please mark if you are currently having problems with any of the below items):

Head/Eyes/Ears/Throat:

_____Hearing Disorder _____Glaucoma _____Sinus Disorder
_____Double Vision _____Ringing Ears _____Other_____
_____Headaches _____Dizziness

Blood:

_____Anemia _____Easy Bruising
_____Sickle Cell _____Difficulty Clotting
_____Thalassemia _____Other_____

Nodes/Glands:

_____Swollen Glands _____Head/Cold Intolerance
_____Excessive Thirst _____Excessive Urination

Breasts:

_____Lumps _____Deformity _____Cysts
_____Pain Prior to Menstruation _____Nipple Discharge _____Other_____

Gastrointestinal:

_____Heartburn _____Blood in Stool _____Constipation
_____Hemorrhoids _____Hepatitis _____Other_____
_____Hernia _____Gall Bladder Disease

Cardiac:

_____Chest Pain _____Heart Palpitations
_____Shortness of Breath _____Other_____

Urinary:

_____Kidney/Bladder Infection _____Kidney Stone _____Pain with Urination
_____Increased Frequency of Urination _____Incontinence of Urine _____Other_____

Skeletal:

_____Broken Bones _____Difficulty Walking _____Unexplained Back Pain
_____Arthritis _____Other_____

Neurologic:

_____Seizures _____Fainting Spells
_____Memory Loss _____Migraine Headaches _____Other_____

Psychiatric:

_____Depression _____Anxiety _____Premenstrual Tension

Gynecologic:

Age of First Period_____ Last Normal Menstrual Period_____
Periods: _____ Regular _____Irregular

Heavy Periods	Yes	No
Prolonged Periods	Yes	No
Painful Periods	Yes	No
Painful Intercourse	Yes	No
Frequent Yeast Infections	Yes	No
Abnormal Discharge	Yes	No

If so, how many pads and/or tampons per day_____
If so, how may days_____
If so, which medications help_____

# of pregnancies_____ # of live births_____ # of miscarriages/abortions_____ # of tubal pregnancies_____

Have you had: Gonorrhea Yes No Syphilis Yes No Chlamydia Yes No Other_____

_____ _____
Patient Signature Date