

REVIEW OF SYSTEMS

Reno Gynecology

343 Elm Street, Suite 306
 Reno NV 89503
 775-324-4477

Name _____

Date _____

Are you currently experiencing any of the following symptoms?

Please check the appropriate box(es), if the answer is "yes"

Constitutional:		Gynecological:	
<input type="checkbox"/>	Fever	<input type="checkbox"/>	Bleeding or pain with intercourse
<input type="checkbox"/>	Chills	<input type="checkbox"/>	Unusual vaginal discharge or odor
<input type="checkbox"/>	Sweats	<input type="checkbox"/>	Vulvar or vaginal itching or burning
<input type="checkbox"/>	Weight change - gain or loss	<input type="checkbox"/>	Pelvic pain
<input type="checkbox"/>	Weakness		
<input type="checkbox"/>	Fatigue	Urinary:	
		<input type="checkbox"/>	Painful urination
Eyes:		<input type="checkbox"/>	Frequent urination
<input type="checkbox"/>	Change in vision	<input type="checkbox"/>	Urinary urgency
		<input type="checkbox"/>	Blood in urine
Ears, Nose, Mouth, Throat:		<input type="checkbox"/>	Urinary incontinence
<input type="checkbox"/>	Change in hearing	<input type="checkbox"/>	Getting up at night to urinate
<input type="checkbox"/>	Nose bleeds		
<input type="checkbox"/>	Sore throat	Musculoskeletal:	
<input type="checkbox"/>	Dry mouth	<input type="checkbox"/>	Back pain
		<input type="checkbox"/>	Weakness
Cardiovascular:		<input type="checkbox"/>	Joint pain, stiffness, swelling
<input type="checkbox"/>	Dizziness		
<input type="checkbox"/>	Shortness of breath	Integumentary / Breast:	
<input type="checkbox"/>	Chest pain	<input type="checkbox"/>	Nodules
<input type="checkbox"/>	Loss of consciousness	<input type="checkbox"/>	Change in moles, freckles
<input type="checkbox"/>	Palpitations	<input type="checkbox"/>	Change in hair - growth, loss, texture
		<input type="checkbox"/>	Breast lumps
Respiratory:		<input type="checkbox"/>	Breast nipple discharge
<input type="checkbox"/>	Chest pain	<input type="checkbox"/>	Breast pain
<input type="checkbox"/>	Cough - productive or dry		
<input type="checkbox"/>	Shortness of breath	Neurological / Psychiatric:	
<input type="checkbox"/>	Wheezing	<input type="checkbox"/>	Memory change
		<input type="checkbox"/>	Depression
Gastrointestinal:		<input type="checkbox"/>	Anxiety
<input type="checkbox"/>	Abdominal pain	<input type="checkbox"/>	Mood swings
<input type="checkbox"/>	Nausea, vomiting	<input type="checkbox"/>	Numbness or tingling
<input type="checkbox"/>	Change in bowel habits		
<input type="checkbox"/>	Change in appetite	Endocrine:	
<input type="checkbox"/>	Dark or bloody stool	<input type="checkbox"/>	Excessive thirst, urination
<input type="checkbox"/>	Indigestion	<input type="checkbox"/>	Tremor
<input type="checkbox"/>	Constipation or diarrhea	<input type="checkbox"/>	Cold or heat intolerance
		<input type="checkbox"/>	Hot flashes
Hematologic / Lymphatic:		<input type="checkbox"/>	Night sweats
<input type="checkbox"/>	Swollen lymph glands	<input type="checkbox"/>	Sleep disturbances
<input type="checkbox"/>	Easy bruisability		

Thank you for taking the time to answer these questions. Most insurance companies now require this information to be updated at every visit.