Health Center at Touro University Nevada

Review of Systems - Female

Are you currently having any problems related to the following systems? Check Yes or No

General

Feeling well ☐ Yes ☐ No
Weight loss/gain ☐ Yes ☐ No
Fatigue ☐ Yes ☐ No
Fever ☐ Yes ☐ No

Integumentary (skin)

New or changing moles ☐ Yes ☐ No
Itching ☐ Yes ☐ No
Rash ☐ Yes ☐ No

HEENT

Eye pain ☐ Yes ☐ No
Change in vision/vision loss ☐ Yes ☐ No
Change in/difficulty hearing ☐ Yes ☐ No
Ear pain ☐ Yes ☐ No
Runny nose ☐ Yes ☐ No
Difficulty swallowing ☐ Yes ☐ No

Respiratory

Cough ☐ Yes ☐ No
Snoring ☐ Yes ☐ No
Difficulty breathing ☐ Yes ☐ No

Breast

Breast lumps ☐ Yes ☐ No
Breast pain ☐ Yes ☐ No
Nipple discharge ☐ Yes ☐ No

Cardiovascular

Chest pain ☐ Yes ☐ No
Palpitations ☐ Yes ☐ No
Waking at night with difficulty breathing ☐ Yes ☐ No
Swelling in legs ☐ Yes ☐ No

Gastrointestinal

Abdominal pain ☐ Yes ☐ No
Black or bloody stool ☐ Yes ☐ No
Constipation ☐ Yes ☐ No
Diarrhea ☐ Yes ☐ No
Heartburn/indigestion ☐ Yes ☐ No
Nausea/vomiting ☐ Yes ☐ No

Genitourinary

Urine loss/leakage ☐ Yes ☐ No
Menstrual irregularities ☐ Yes ☐ No
Awaken at night to urinate ☐ Yes ☐ No
Painful urination ☐ Yes ☐ No
Strong/sudden urge to urinate ☐ Yes ☐ No
Vaginal discharge/bleeding ☐ Yes ☐ No

Musculoskeletal

Back pain ☐ Yes ☐ No
Joint pain ☐ Yes ☐ No
Have you given up any activity due to pain? ☐ Yes ☐ No

Neurological

Numbness/tingling ☐ Yes ☐ No
Difficulty speaking ☐ Yes ☐ No
Headaches ☐ Yes ☐ No

Psychological

Difficulty with sleep ☐ Yes ☐ No
Anxiety ☐ Yes ☐ No
Depression ☐ Yes ☐ No

Endocrine

Excessive thirst ☐ Yes ☐ No
Heat/cold intolerance ☐ Yes ☐ No

Hematology

Easy Bruising/nosebleeds ☐ Yes ☐ No

Name______________________________ Date______________________