Bloomington Obstetrics & Gynecology

# Review of Systems and Gynecological Examination

Name _____ SSN _____ Date _____

DOB _____ Age _____ Phone #s Home _____ Work _____

**Are You Currently Having Any Problems With: (please circle)**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| fever | weight change | dizziness | headache | anxiety | depression | skin | bones/joints |
| muscles | nerves | eyes | ears | nose | sinus | throat | heart |
| blood pressure | breathing | chronic cough | bloody sputum | swallowing | nausea | vomiting | bowel changes |
| rectal bleeding | pelvic pain | abdominal pain | kidneys | urinary leakage | bladder | breast lump | breast discharge |

Menstrual periods_____ Menopause symptoms _____

Other _____

Do you smoke? Y N _____ packs per day Drink alcohol (greater than 5 drinks per week)? Y N _____

Use street drugs? Y N _____ Do you have any questions related to sexual issues? Y N

Are you sexually active? Y N Do you need contraception/birth control? Y N

**Current Medication** (by name and dosage) _____

_____

_____

Drug allergies? _____ History of abnormal Pap test? Y N When? _____

Recent surgery or change in health? _____

Update family history of major health problems? _____

Reviewed with Patient _____

(Provider signature)

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**For Office Use Only**