REVIEW OF SYSTEMS

Please check if any of the following applies to you TODAY:

CONSTITUTIONAL		Notes
Weight Loss	❒	
Weight Gain	❒	
Fever	❒	
Fatigue	❒	
Night Sweats	❒	
Hot Flashes	❒	
EYES		
Double vision	❒	
Vision changes	❒	
HENT		
Headaches	❒	
Dizziness	❒	
Sore Throat	❒	
Sinus Pain	❒	
Nose Bleeding	❒	
Thyroid Mass	❒	
Neck Pain	❒	
BREASTS		
Lumps	❒	
Tenderness	❒	
Swelling	❒	
Discharge	❒	
Pain in Breast	❒	
Abn. Changes in Breast	❒	
CARDIOVASCULAR		
Chest Pain	❒	
Irregular Heart Beats	❒	
Rapid Heart Rate	❒	
Fainting	❒	
Swelling of Legs	❒	
Varicose Veins	❒	
RESPIRATORY		
Wheezing	❒	
Cough	❒	
Shortness of Breath	❒	
Spitting Up Blood	❒	
GASTROINTESTINAL		
Nausea	❒	
Vomiting	❒	
Diarrhea	❒	
Constipation	❒	
Abdominal Pain	❒	
Bloody/Black Stool	❒	
Hemorrhoids	❒	
Jaundice	❒	
GENITOURINARY		
Urgency of Urination	❒	
Frequency of Urination	❒	
Pain with Urination	❒	
Nighttime Urination	❒	
Losing Urine	❒	

GENITOURINARY, Continued		Notes
Decreased Sex Drive	❒	
Painful Intercourse	❒	
Possible Pregnancy	❒	
Genital Sores	❒	
SKIN		
Rashes	❒	
Itching	❒	
Skin Dryness	❒	
Skin Lesions	❒	
Changes to Lesions or Moles	❒	
Acne	❒	
NEUROLOGICAL		
Muscular Weakness	❒	
Numbness or Tingling	❒	
Difficulty Concentrating	❒	
Memory Difficulties	❒	
Speech Difficulties	❒	
Seizures	❒	
Loss of Balance	❒	
MUSCULOSKELETAL		
Joint Pain or Swelling	❒	
Muscle Pain	❒	
Back Pain	❒	
ENDOCRINE		
Loss of Hair	❒	
Difficulty Tolerating Cold	❒	
Difficulty Tolerating Heat	❒	
PSYCHIATRIC		
Anxiety	❒	
Depression	❒	
Impulsive Behavior	❒	
Suicidal Thoughts	❒	
Excessive Anger	❒	
Mood Swings	❒	
Emotional Abuse	❒	
Physical Abuse	❒	
Sexual Abuse	❒	
HEMATOLOGIC/LYMPHATIC		
Bruises Frequently or Easily	❒	
Cuts do not stop Bleeding	❒	
Enlarged Lymph Nodes	❒	
ALLERGIC/IMMUNOLOGIC		
Frequent Illness	❒	
Seasonal Allergies	❒	
OTHER		
1.		
2.		

Please complete this form and:
- ❒ Bring it to your appointment
- ❒ Mail it in the enclosed envelope
- ❒ Fax it to: (423) 875-8510 at least one day before your appointment.

North Park OB-GYN Associated, PC

Today's date: ______/______/______

Name ____________________ Preferred Name ____________________

Address ____

Birthdate ____/____/____ Social Security Number ____________________

Home Phone (_____) __________ Work Phone (_____) __________ Cell Phone (_____) __________

Primary Physician ____________________ Partner's Name ____________________

Reason for Visit: ❒ Routine Annual Exam ❒ Problem

Describe Problem ____

CHECK IF YOU HAVE HAD ANY OF THESE MEDICAL PROBLEMS IN THE PAST & LIST DATE:

- ❒ Anemia ______
- ❒ Anxiety ______
- ❒ Arthritis/Joint Pain ______
- ❒ Asthma ______
- ❒ Blood Transfusions ______
- ❒ Bowel Trouble ______
- ❒ Breast Cancer ______
- ❒ Cancer ______
- ❒ Chicken Pox ______
- ❒ Chlamydia ______
- ❒ Chronic Lung Disease ______
- ❒ Depression ______
- ❒ Diabetes ______
- ❒ Eating Disorder ______
- ❒ Fracture ______
- ❒ Glaucoma ______
- ❒ Gonorrhea / GC ______
- ❒ Heart Murmur ______
- ❒ Heart Trouble ______
- ❒ Hepatitis/Jaundice ______
- ❒ Herpes/HSV ______
- ❒ High Blood Pressure ______
- ❒ High Cholesterol ______
- ❒ HIV/AIDS ______
- ❒ HPV/Human Papilloma Virus ______
- ❒ Kidney Infection ______
- ❒ Urinary Tract Infect. ______
- ❒ Kidney Stones ______
- ❒ Mood Disorders ______
- ❒ Pneumonia ______
- ❒ Rheumatic Fever ______
- ❒ Sexually Transmitted Diseases ______
- ❒ Stroke ______
- ❒ Syphilis ______
- ❒ Tuberculosis - TB ______
- ❒ Thyroid Disease ______
- ❒ Ulcers ______
- ❒ Other: ______

PLEASE LIST ANY OPERATIONS OR HOSPITALIZATIONS YOU HAVE HAD:

Surgery/Hospitalization/Reason	Date

WHEN WAS YOUR LAST TEST OR IMMUNIZATION?

- ❒ Bone Density .... Date ______
- ❒ Colonoscopy / Sigmoidoscopy .... Date ______
- ❒ Mammogram .... Date ______
- ❒ Last Normal PAP Smear .... Date ______
- ❒ Last Abnormal PAP Smear .... Date ______

Form # 22813

PLEASE LIST MEDICATIONS THAT YOU ARE CURRENTLY TAKING:

Drug Name	Dosage	Physician

List Any Allergies to Medications/Substances (latex gloves, etc.): ______________________________

YOUR GYN HISTORY

Were you using any birth control when you got pregnant? ❒ Yes ❒ No

- ❒ Condoms
- ❒ Depo Provera
- ❒ Diaphragm
- ❒ IUD: Kind ____________ Date Inserted ____________
- ❒ Birth Control Pill Name of Pill ____________
- ❒ Contraceptive Foam/Jelly
- ❒ Nuvaring
- ❒ Birth Control Patch
- ❒ None
- ❒ Natural Family Plan/Rhythm
- ❒ Tubal Ligation
- ❒ Vasectomy
- ❒ Withdrawal
- ❒ Other: ____________

What age did you have your first period? ____________
How many days are there from the start of your period to the start of your next period? ______ days
How long does your period last? ________ days Flow: ❒ Light ❒ Medium ❒ Heavy
What number of tampons or pads are used in a day?____________
Do you pass clots? ❒ Yes ❒ No
Date of last period:____________ Are you sure of the date? ❒ Yes ❒ No
Was it a normal period? ❒ Yes ❒ No
Have you had a home urine pregnancy test? ❒ Yes ❒ No When: ____________
Have you had an office urine pregnancy test? ❒ Yes ❒ No When: ____________
Have you had an office blood pregnancy test? ❒ Yes ❒ No When: ____________
Have you had recent abnormal bleeding? ❒ Yes ❒ No When: ____________

IF YOU HAVE STOPPED HAVING PERIODS, PLEASE ANSWER THE QUESTIONS BELOW:

Age of Menopause____________ Do you take prescription hormones now? ❒ Yes ❒ No
Did you take hormones in the past? ❒ Yes ❒ No Do you take herbal hormones? ❒ Yes ❒ No

YOUR OB HISTORY

	Number		*Number*
Total Number of Pregnancies		Full Term Births	
Premature Delivery (less than 37 weeks)		Abortions/Termination	
Miscarriages		Living Children	

On the chart below, please fill in answers for each pregnancy including abortions or miscarriages.

No.	Birth Date	Wks. Gest.	Labor (hrs.)	Baby's Weight/Sex	Del. Type Vag/Csection	Epid Y/N	Preterm Labor?	Wt. Gain	Comments/ Complications	Hospital
1				❒M ❒F						
2				❒M ❒F						
3				❒M ❒F						
4				❒M ❒F						

CHECK ANY THAT APPLY AND LIST IF YOUR BLOOD RELATIVES HAVE HAD:

Major Illnesses	Yes	What Blood Relative? Mother's Father's
Anemia		
Arthritis / Joint Pain		
Asthma		
Bowel Troubles / Ulcers		
Breast Cancer		
Cancer		
Chronic Lung Disease		
Depression / Anxiety / Mood Disorders		
Diabetes		
Glaucoma		
Heart Trouble / Murmur		
Hepatitis / Jaundice		
High Blood Pressure		
High Cholesterol		
Kidney Infections / Stones		
Stroke		
Thyroid Disease		
Tuberculosis - TB		
Other:		

SOCIAL HISTORY

Do you exercise? ❒ None ❒ Less than 3 times per week ❒ More than 3 times per week
Do you have sex with: ❒ Men ❒ Women ❒ Both
First Intercourse at age:________ New sexual partner? ❒ Yes ❒ No
Lifetime sexual partners ❒ Less than 5 ❒ More than 5
Do you have any sexual problems you want to discuss today? ❒ Yes ❒ No
Describe: ____________
Do you want to be screened for HIV/AIDS? ❒ Yes ❒ No (This screening is NOT covered by insurance.)
Do you want to be screened for other STD's? ❒ Yes ❒ No
Have you ever had a blood transfusion? ❒ Yes ❒ No Date:____________
Smoking: ❒ Yes ❒ No ❒ Previously Packs per day________ # of years________ Stopped ______ Years Ago
Alcohol ❒ Yes ❒ No ❒ Previously Drinks per day________ Drinks per week________
Caffeine ❒ Yes ❒ No Drinks per day________ Drinks per week________
Drug user ❒ Yes ❒ No ❒ Previously Kind/Type____________ Frequency____________
History of Abuse ❒ Yes ❒ No ❒ Physical ❒ Emotional ❒ Sexual
Are you in a relationship with someone who physically threatens or hurts you? ❒ Yes ❒ No
List all "Natural" or "Herbal" remedies, over the counter drugs, vitamins, or minerals you are taking: ____________

Highest Grade Completed in School: ❒ GED ❒ High School ❒ Attended Some College
❒ Associate Degree (2 years) ❒ Bachelor's Degree (4 years) ❒ Post-Graduate
❒ Some Graduate Work ❒ Did not attend school ❒ Did not complete high school
Other: ____________
Occupation:____________
Race: ❒ White ❒ African American ❒ Hispanic ❒ Asian ❒ Other____________
Marital Status: ❒ Single ❒ Engaged ❒ Married ❒ Divorced ❒ Widowed