



**Review of Systems**

Name: \_\_\_\_\_ DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Please check (✓) the appropriate box(es) if you have experienced, either recently or within the last year, any of the following symptoms or conditions.

1. Constitutional	<input type="checkbox"/> None <input type="checkbox"/> Loss of Appetite	<input type="checkbox"/> Weight Loss	<input type="checkbox"/> Weight Gain <input type="checkbox"/> Other _____	<input type="checkbox"/> Fever	<input type="checkbox"/> Fatigue
2. Eyes	<input type="checkbox"/> None <input type="checkbox"/> Other _____	<input type="checkbox"/> Vision Change	<input type="checkbox"/> Glasses/Contacts	<input type="checkbox"/> Dryness	<input type="checkbox"/> Discharge
3. Ears, Nose & Throat	<input type="checkbox"/> None <input type="checkbox"/> Sore Throat/Hoarseness	<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Sinusitis <input type="checkbox"/> Other _____	<input type="checkbox"/> Headache	<input type="checkbox"/> Ulcers
4. Cardiovascular	<input type="checkbox"/> None <input type="checkbox"/> Difficulty Breathing with exertion <input type="checkbox"/> Varicose Veins	<input type="checkbox"/> Palpitation <input type="checkbox"/> Spider Veins	<input type="checkbox"/> Chest Pain <input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Swelling <input type="checkbox"/> Difficulty Breathing While Lying Down <input type="checkbox"/> Other _____	
5. Respiratory	<input type="checkbox"/> None <input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Coughing Blood <input type="checkbox"/> Other _____	<input type="checkbox"/> Persistent Cough	
6. Gastrointestinal	<input type="checkbox"/> None <input type="checkbox"/> Flatulence	<input type="checkbox"/> Constipation <input type="checkbox"/> Nausea/Vomiting/Indigestion	<input type="checkbox"/> Bloody Stool	<input type="checkbox"/> Diarrhea <input type="checkbox"/> Other _____	<input type="checkbox"/> Pain
7. Genitourinary	<input type="checkbox"/> None <input type="checkbox"/> Painful Urination <input type="checkbox"/> Abnormal Vaginal Bleeding <input type="checkbox"/> Bulge in Vagina <input type="checkbox"/> Vaginal Discharge	<input type="checkbox"/> Urinary Urgency <input type="checkbox"/> Blood in Urine <input type="checkbox"/> Pelvic Pressure <input type="checkbox"/> Odor	<input type="checkbox"/> Urinary Frequency <input type="checkbox"/> Incomplete Voiding <input type="checkbox"/> PMS <input type="checkbox"/> Vaginal/Vulvar Itching <input type="checkbox"/> Other _____	<input type="checkbox"/> Urinary Incontinence <input type="checkbox"/> Abnormal or Painful Periods <input type="checkbox"/> Vaginal/Vulvar Lesion	
8. Muskuloskeletal	<input type="checkbox"/> None <input type="checkbox"/> Other _____	<input type="checkbox"/> Muscle or Joint Pain		<input type="checkbox"/> Muscle Weakness	
9a. Skin	<input type="checkbox"/> None <input type="checkbox"/> Other _____	<input type="checkbox"/> Dry/Itchy Skin	<input type="checkbox"/> Pigmented Lesions	<input type="checkbox"/> Rash	<input type="checkbox"/> Ulcers
9b. Breast	<input type="checkbox"/> None <input type="checkbox"/> Other _____	<input type="checkbox"/> Pain	<input type="checkbox"/> Nipple Discharge	<input type="checkbox"/> Mass	
10. Neurologic	<input type="checkbox"/> None <input type="checkbox"/> Loss of Consciousness <input type="checkbox"/> Dizziness	<input type="checkbox"/> Seizures <input type="checkbox"/> Other _____	<input type="checkbox"/> Numbness <input type="checkbox"/> Balance Problem	<input type="checkbox"/> Difficulty Walking <input type="checkbox"/> Memory Problems	
11. Psychiatric	<input type="checkbox"/> None <input type="checkbox"/> Irritability	<input type="checkbox"/> Depression <input type="checkbox"/> Other _____	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Mood Swings	
12. Endocrine	<input type="checkbox"/> None <input type="checkbox"/> Frequent Thirst <input type="checkbox"/> Other _____	<input type="checkbox"/> Hair Loss <input type="checkbox"/> Frequent Hunger	<input type="checkbox"/> Hot Flashes <input type="checkbox"/> Loss of Appetite	<input type="checkbox"/> Hot/Cold Intolerance <input type="checkbox"/> Frequent Urination	
13. Hematologic/ Lymphatic	<input type="checkbox"/> None <input type="checkbox"/> Swelling in Hands/Feet	<input type="checkbox"/> Bruising	<input type="checkbox"/> Bleeding <input type="checkbox"/> Other _____	<input type="checkbox"/> Swollen Glands	
14. Allergic/ Immunologic	<input type="checkbox"/> None <input type="checkbox"/> Other _____	<input type="checkbox"/> Sneezing	<input type="checkbox"/> Nasal Congestion	<input type="checkbox"/> Watery/Itchy Eyes	

**IN CASE OF EMERGENCY, WHO SHOULD WE CONTACT?**

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_  
 ADDRESS: \_\_\_\_\_ PHONE: ( ) \_\_\_\_\_

**INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS AND INFORMATION RELEASE**

I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim. I request that any payment of authorized benefits be made on my behalf. I assign the benefits payable to which I am entitled, including Medicare and private insurance and other health plans, to Obstetrical Associates. This agreement will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as The original. I understand that I am financially responsible for all charges whether or not paid by said insurance.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_