



**REVIEW OF SYSTEMS (FEMALE)**

Please Indicate Yes or No to the following

	Yes	No		Yes	No
<b>CONSTITUTION</b>			<b>GENITOURINARY</b>		
Appetite change	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty urinating	<input type="checkbox"/>	<input type="checkbox"/>
Chills	<input type="checkbox"/>	<input type="checkbox"/>	Painful Intercourse	<input type="checkbox"/>	<input type="checkbox"/>
Sweating	<input type="checkbox"/>	<input type="checkbox"/>	Pain urinating	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Increased frequency urinating	<input type="checkbox"/>	<input type="checkbox"/>
Fever	<input type="checkbox"/>	<input type="checkbox"/>	Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>
Unexpected weight change	<input type="checkbox"/>	<input type="checkbox"/>	Incontinence	<input type="checkbox"/>	<input type="checkbox"/>
<b>HEAD, EARS, NOSE, THROAT</b>			<b>MUSCULOSKELETAL</b>		
Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>	Joint pain	<input type="checkbox"/>	<input type="checkbox"/>
Lump/Mass	<input type="checkbox"/>	<input type="checkbox"/>	Back pain	<input type="checkbox"/>	<input type="checkbox"/>
Mouth sores	<input type="checkbox"/>	<input type="checkbox"/>	Flank pain	<input type="checkbox"/>	<input type="checkbox"/>
Nosebleeds	<input type="checkbox"/>	<input type="checkbox"/>	Muscle aches	<input type="checkbox"/>	<input type="checkbox"/>
Sore throat	<input type="checkbox"/>	<input type="checkbox"/>	Neck pain	<input type="checkbox"/>	<input type="checkbox"/>
Ringling in ears	<input type="checkbox"/>	<input type="checkbox"/>	Neck stiffness	<input type="checkbox"/>	<input type="checkbox"/>
Trouble swallowing	<input type="checkbox"/>	<input type="checkbox"/>	<b>SKIN</b>		
Voice change	<input type="checkbox"/>	<input type="checkbox"/>	Itching	<input type="checkbox"/>	<input type="checkbox"/>
<b>EYES</b>			Rash	<input type="checkbox"/>	<input type="checkbox"/>
Eye problems	<input type="checkbox"/>	<input type="checkbox"/>	Wound	<input type="checkbox"/>	<input type="checkbox"/>
Yellow eyes	<input type="checkbox"/>	<input type="checkbox"/>	<b>NEUROLOGICAL</b>		
<b>RESPIRATORY</b>			Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Chest tightness	<input type="checkbox"/>	<input type="checkbox"/>	Gait problem	<input type="checkbox"/>	<input type="checkbox"/>
Cough	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Coughing blood	<input type="checkbox"/>	<input type="checkbox"/>	Lightheadedness	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Numbness	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
<b>CARDIOVASCULAR</b>			Speech difficulty	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	Extremity weakness	<input type="checkbox"/>	<input type="checkbox"/>
Leg swelling	<input type="checkbox"/>	<input type="checkbox"/>	<b>HEMATOLOGIC</b>		
Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	Enlarged lymph nodes	<input type="checkbox"/>	<input type="checkbox"/>
<b>GASTROINTESTINAL</b>			Bruise or Bleed Easily	<input type="checkbox"/>	<input type="checkbox"/>
Abdominal distention	<input type="checkbox"/>	<input type="checkbox"/>	<b>PSYCHIATRIC</b>		
Abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Blood in stool	<input type="checkbox"/>	<input type="checkbox"/>	Confusion	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Decreased concentration	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>
Nausea	<input type="checkbox"/>	<input type="checkbox"/>	Trouble sleeping	<input type="checkbox"/>	<input type="checkbox"/>
Rectal pain	<input type="checkbox"/>	<input type="checkbox"/>	Suicidal ideas	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting	<input type="checkbox"/>	<input type="checkbox"/>			
<b>ENDOCRINE</b>					
Hot flashes	<input type="checkbox"/>	<input type="checkbox"/>			
Other (write in):					