

Review of Systems

Do you now or have you had any problems related to the following systems? Circle Yes or No.

Please explain any Yes answers in space provided.

Constitutional Symptoms

Fever Y N
Chills Y N
Headache Y N
Other: _____

Gastrointestinal

Abdominal Pain Y N
Nausea / Vomiting Y N
Indigestion/Heartburn Y N
Other: _____

Respiratory

Wheezing Y N
Frequent Cough Y N
Shortness of Breath Y N
Other: _____

Eyes

Blurred Vision Y N
Double Vision Y N
Pain Y N
Other: _____

Cardiovascular

Chest Pain Y N
Varicose Veins Y N
High Blood Pressure Y N
Other: _____

Hematologic / Lymphatic

Swollen glands Y N
Blood clotting problem Y N
Other: _____

Allergic / Immunologic

Hay Fever Y N
Drug Allergies Y N
Other: _____

Integumentary

Skin Rash Y N
Boils Y N
Persistent Itch Y N
Other: _____

Psychologic

Are you generally satisfied with your life? Y N
Do you feel severely depressed? Y N
Have you considered suicide? Y N

Neurological

Tremors Y N
Dizzy Spells Y N
Numbness/Tingling Y N
Other: _____

Musculoskeletal

Joint Pain Y N
Neck Pain Y N
Back Pain Y N
Other: _____

Female History

Are you periods normal? Y N
If no, describe:
Recent vaginal discharge Y N
Have you been on birth control? Y N
Now Past
Have you had prior surgery on uterus, ovaries, or vagina? Y N
How many pregnancies? _____
How many children born? _____
Last period? _____
What type of contraception are you using? _____

Endocrine

Excessive thirst Y N
Too Hot/Cold Y N
Tired/Sluggish Y N
Diabetes Y N
Other: _____

Ear/Nose/Throat/Mouth

Ear Infection Y N
Sore Throat Y N
Sinus Problems Y N
Other: _____

- On average, about how many times a day do you urinate? _____ times a day.
- On average, how many times during the night do you urinate? _____
- During a typical day, how many protective pads do you wear? _____ diapers _____ maxi pads _____ panty liners
- Do you leak urine at night in bed? _____ Yes _____ No
- How often do you have such a strong urge to urinate that you expect leakage before you reach the toilet?
_____ Often _____ Sometimes _____ Seldom _____ Never
Do you ever actually experience leakage at these times? _____ Yes _____ No
- How often do you leak urine when you sneeze, cough, laugh or exercise?
_____ Often _____ Sometimes _____ Seldom _____ Never
- Which causes most of your leakage? _____ above #5 _____ above #6
- do you have to strain to get a urine stream started? _____ Yes _____ No
- Do you feel like you empty your bladder? _____ Yes _____ No
- How often do you experience pain or discomfort when you urinate? _____ Often _____ Sometimes _____ Seldom _____ Never
- Have you ever had surgery to correct urinary incontinence? _____ Yes _____ No
- How long have you had urinary incontinence? _____ Years _____ Months