Casper Women's Care, PC

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Patient Review of Systems

Please complete this form before today's appointment, and **only check boxes if these symptoms apply to your visit TODAY**. If you do not have any complaints, check the box at the bottom of the page. Please sign your name after you have verified that the information you have provided is correct.

Patient Name: _____DOB: _____Date: _____

General	☐ Weight Loss ☐ Weight Gain ☐ Fever ☐ Fatigue ☐ Sleep Disturbances
Breast	☐ Breast Pain ☐ Breast Mass/Lump ☐ Nipple Discharge
Urinary	☐ Frequency/Urgency ☐ Leaking Urine ☐ Bloody Urine ☐ Burning/Pain
Chest	☐ Hand/Ankle Swelling ☐ Chest Pain ☐ Palpitations ☐ Shortness of Breath ☐ Difficulty Breathing ☐ Wheezing ☐ Coughing Blood ☐ Chronic Cough
Stomach and Intestines	☐ Nausea/Vomiting ☐ Bloody Stool ☐ Constipation ☐ Chronic Diarrhea ☐ Excessive Gas ☐ Hemorrhoids ☐ Difficulty Controlling Bowel ☐ Abdominal Pain
Vaginal	☐Abnormal discharge ☐ Itching/burning ☐ Dryness ☐ Painful Intercourse ☐ Pelvic Pain ☐ Abnormal/Painful Periods ☐ Abnormal Bleeding
Psychological/Neurological	☐ Depression ☐ Fainting ☐ Seizures ☐ Numbness
Endocrine	☐ Heat/Cold Intolerance ☐ Hair Loss/ Growth ☐ Hot Flashes
Muscles/Bones	☐ Muscle Pain ☐ Muscle Weakness ☐ Joint Pain

☐ I have read everything in the categories above, ***and do not have any above listed complaints for my visit today.***

The above information is correct to the best of my knowledge: _____
Signature of Patient

Review of systems was reviewed and discussed with patient at today's visit.

Signature of Provider: _____Date: _____