# *Review of Systems – Aurora Women's Health*

Name:______________________________ Date:____________

DOB:____________ Age:_____ Sex:_____

**General**
fever, chills, malaise, fatigue/energy, night sweats, weight changes
other:______________________________________

**Diet**
appetite, restrictions, vitamins, supplements
other:______________________________________

**Skin, Hair, Nails**
rash, eruptions, itching, pigment changes, hair loss or changes, new moles or lesions
other:______________________________________

**Head & Neck**
headaches, dizziness, head injuries, loss of consciousness
other:______________________________________

**Eyes**
blurring, double vision, visual changes, glasses, trauma, irritation, pain, discharge
other:______________________________________

**Ears**
hearing loss, pain, discharge, vertigo, tinnitus
other:______________________________________

**Nose**
congestion, nose bleeds, postnasal drip, changes in smell, rhinorrhea
other:______________________________________

**Throat & Mouth**
hoarseness, sore throat, bleeding gums, ulcers, tooth problems, difficulty swallowing, changes in voice
other:______________________________________

**Male**
puberty onset, erections, testicular pain, libido, penile discharge, testicular lumps, difficulty urinating
other:______________________________________

**Breasts**
pain, tenderness, lumps, nipple discharge, skin or pigment changes
other:______________________________________

**Chest & Lungs**
cough, sputum, shortness of breath with or without exertion, wheezing, night sweats, exposure to TB
other:______________________________________

**Cardiovascular**
chest pain, palpations, # of pillows needed to sleep, leg or ankle swelling, leg pain or cramps when walking, exercise intolerance, heartburn
other:______________________________________

**Hematology**
anemia, easy bruising
other:______________________________________

**Genitourinary**
Pain with urination, flank pain, urgency, frequency, getting up at night to urinate, # of times________ , blood in urine, dribbling or incontinence
other:______________________________________

**Musculoskeletal**
joint pain, heat, swelling, weakness, loss of coordination, loss or mobility
other:______________________________________