

Jessica Davis MD

The New Mom's Family Doctor

781 Hudson Avenue | PO Box 173 | Stillwater, NY 12170

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REVIEW OF SYSTEMS

Check the Yes or No column for any symptoms that are CURRENTLY a problem for you.

Yes	No	General	Yes	No	Dermatology	Yes	No	GI
		Fever			Rash			Nausea
		Chills			Itching			Vomiting
		Sweats			Dryness			Diarrhea
		Fatigue			Suspicious moles			Constipation
		Decreased appetite	Yes	No	Musculoskeletal			Change in bowel habits
		Weakness			Back pain			Abdominal pain
		Just don't feel well			Joint pain			Black or tar-like stools
		Weight loss			Joint swelling			Bloody stools
		Sleep problems			Muscle cramps			Gas/Bloating
Yes	No	Eyes			Muscle weakness			Indigestion/Heartburn
		Blurred vision			Stiffness			Difficulty Swallowing
		Double vision			Arthritis			Feel full early
		Eye discharge			Sciatica	Yes	No	Neurology
		Vision change or loss			Restless legs			Paralysis
		Eye pain			Leg pain at night			Unusual sensations
		Sensitivity to light	Yes	No	Psychiatric			Seizures
Yes	No	Ears/Nose/Throat			Depression			Tremors
		Earache			Anxiety			Vertigo/Dizziness
		Ear discharge			Memory loss			Frequent falls
		Tinnitus/Ringing			Suicidal Thoughts			Frequent headaches
		Decreased hearing			Hallucinations			Difficulty walking
		Nasal congestion			Paranoia	Yes	No	Cardiovascular
		Hoarseness			Phobia/Fear of things			Chest pains
		Nosebleeds			Confusion			Palpitations
Yes	No	Respiratory			Trouble concentrating			Skipped beats
		Cough	Yes	No	Allergy			Syncope/Fainting
		Difficulty breathing			Hives			Difficulty breathing
		• at rest			Frequent infections			• on exertion
		Excessive sputum			Itchy eyes			• when lying down
		Wheezing	Yes	No	Endocrinology			Shortness of breath at night
		Coughing up blood			Constantly cold			Swelling in your legs or ankles
		Pain with deep breath			Constantly hot			
Yes	No	Hematology			Constantly thirsty	Yes	No	Other?
		Unusual bruising			Constantly hungry			
		Unusual bleeding			Unusual weight change			
		Swollen lymph nodes						

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REVIEW OF SYSTEMS (continued)

Yes	No	Reproductive	Yes	No	Reproductive	Yes	No	Urinary
		Vaginal bleeding			Pelvic pain			Incontinence/urine leak
		Missed periods			Infertility			Painful urination
		Heavy periods			Vaginal dryness			Blood in the urine
		PMS			Hot Flashes			Frequent urination
		Vaginal discharge			Decreased libido			
		Genital sores			Painful intercourse			

GYNECOLOGIC HISTORY

OBSTETRIC HISTORY: Provide number of each in the box.

<input type="text"/>	Pregnancies	<input type="text"/>	Caesarean	<input type="text"/>	Vaginal Deliveries
<input type="text"/>	Miscarriage	<input type="text"/>	Abortion	<input type="text"/>	Living Children
Check any that apply:					
<input type="text"/>	Postpartum Depression	<input type="text"/>	Toxemia/Exclampsia	<input type="text"/>	Gestational Diabetes
<input type="text"/>	Baby over 8 pounds	<input type="text"/>	Breast Feeding (how long?)	_____	

MENSTRUAL HISTORY:

Age at first period: _____ Menses Frequency: _____ Length: _____ Pain: **Yes No**

Has your period ever skipped? **Yes No** For how long? _____

Last Menstrual Period: _____

Do you currently use hormonal contraception such as: *(please circle)* **Birth Control Pills / Patch / NuvaRing**

How long have you been on it? _____

Do you use other contraception? **Yes No** **Condom / Diaphragm / IUD / Partner Vasectomy**

Are you in Menopause? **Yes No Not Sure**

Age at menopause? _____

To the best of my knowledge, this is a complete and accurate statement of my health:

Signature: _____ **Date:** ____ - ____ - ____