FEMALE REVIEW OF SYMPTOMS

NAME: _____ DATE: _____

Please circle **ONLY** if applicable.

GENERAL CONSTITUTIONAL

Change in appetite

Weight gain

Weight loss

Pain

Mood change

Difficulty sleeping

Night sweats

Fever

Chills

Dizziness

Diabetes

Fatigue

Weakness

HEENT

Vision problems

Vision change

Glaucoma

Ear problems

Sinus problems

Nose bleeds

Mouth or teeth problems

Difficulty swallowing

Frequent sore throats

CARDIOVASCULAR/ RESPIRATORY

Chest pain

Shortness of breath

Palpitations

Swelling

Fainting

Wheezing

Cough

GASTROINTESTINAL

Abdominal pain

Nausea

Vomiting

Heartburn

Change in stool

Change in stool consistency

Change in bowel habits

Losing control of bowels

Constipation

Diarrhea

Excessive belching

Excessive flatulence

Blood in stool

Daily BM

GENITOURINARY: MENSTRUATING

Losing control of urine

Urinary urgency

Frequent urination

Night-time urination

Difficulty urinating

Reduced stream

Dribbling

Burning or pain on urination

Blood in urine

Pelvic pain

Lumps/growths

Change in periods

Normal menstrual cycles

Missed period

Menstrual cramps

Heavy bleeding

Itching

Odor

Genital sores

Vaginal discharge

Vaginal dryness

Pain with intercourse

Bleeding after intercourse

Decreased desire

INTEGUMENTARY

Bruising

Dry skin

Hives

Itching

Skin lumps/mass

Mole changes

Sores

Rash

Hair changes

Nail changes

Breast lump/mass

Breast pain

Nipple discharge

Dimpling/puckering of the breast

Changes in breast symmetry

Performs monthly self breast exam

Stretch marks

Varicose veins

Phlebitis

NEUROLOGICAL

Migraines

Seizures

Fainting

Vertigo

Ringing in the ears

Short term memory problems

Confusion/disorientation

Change in personality

Speech changes

Numbness/tingling

Muscle weakness

Involuntary movements

Trouble with coordination

Tremors

Balance problems

Losing control of urine or bowel

PSYCHIATRIC

Anxiety

Nervousness

Depression

Sadness

Frequent crying

Sleep problems

Suicidal thoughts

Homicidal thoughts

Mood swings

MUSCULOSKELETAL

Limited join mobility

Joint pain

Muscle pain

Stiffness

Tenderness

Muscle weakness

ALLERGIC/IMMUNOLOGIC

Latex allergy

Environmental allergies

Immunodeficiency

ENDOCRINE

Excessive appetite

Excessive sweating

Excessive thirst

Excessive urination

Heat intolerance

Cold intolerance

Hair loss

Unexpected hair growth

Excess hair growth

HEMATOLOGIC/ LYMPHATIC

Easy bleeding or bruising

Anemia

Swollen glands

QUESTIONNAIRE 1

Do you exercise?

Do you eat three meals a day?

Do you sleep an average of 6-8 hours?

Do you enjoy your work?

Do you watch more than 2 hours of TV a day?

Do you take vacations?