Eastwind Women's Health

Name: _____ **Date of Birth:** ___/___/___

Today's Date: ___/___/___

Gynecology Review of Systems: Please check any symptoms you are ***currently*** experiencing. Please give to the medical assistant who takes you to your exam room.

Please fill out both sides of this form.

Date of last menstrual period: _____

Preferred pharmacy name and phone number:

_____

Fatigue ___

Fever ___

Night Sweats ___

Hot Flashes ___

Ear Drainage ___

Eye Discharge ___

Hearing Loss ___

Nasal Drainage ___

Vision changes ___

Cough ___

Dysmenorrhea (painful periods) ___

Irregular Menses ___

Painful intercourse ___

Vaginal Discharge ___

Puritis (itching) ___

Rash ___

Gait Disturbance (difficulty walking) ___

Anxiety ___

Depression ___

Cold intolerance (often too cold) ___

See other side

Shortness of breath ___

Wheezing ___

Chest Pain ___

Heat intolerance (often too hot) ___

Polydipsia (increased thirst) ___

Polyphagia (increased hunger) ___

Claudication (pain/cramping in lower leg) ___

Palpitations (irregular/rapid heartbeat) ___

Muscle weakness ___

Abdominal Pain ___

Constipation ___

Diarrhea ___

Vomiting ___

Dysuria (pain with urination) ___

Hematuria (blood in urine) ___

Breast Discharge ___

Joint swelling ___

Easy bleeding ___

Easy bruising ___

Environmental allergies ___

Food Allergies ___

Polyuria (urinary frequency) ___

Breast mass ___

Menorrhagia (heavy bleeding) ____

***Below, please list any medications you are currently taking along with dosage and the reason you are taking the medication.**

Medication	**Dosage**	**Reason Taking**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____