PALO PINTO GENERAL HOSPITAL
400 SW 25th AVENUE
MINERAL WELLS, TX 76067
(940) 325-7891

Female Review of Systems

Name: _____ Date of Birth: _____

Please check any current symptoms you have.

General:

YES	NO	
☐	☐	Chills
☐	☐	Fever
☐	☐	Weight Gain
☐	☐	Weight Loss
☐	☐	Headaches

HEENT:

YES	NO	
☐	☐	Blurred Vision
☐	☐	Wear Glasses/Contact Lenses
☐	☐	Hearing Loss
☐	☐	Ringing Ears
☐	☐	Nose Bleeds
☐	☐	Chronic Sinus Infections
☐	☐	Bleeding Gums

Respiratory:

YES	NO	
☐	☐	Bloody Sputum
☐	☐	Chronic Cough
☐	☐	Difficulty in Breathing
☐	☐	Wheezing

Cardiovascular:

YES	NO	
☐	☐	Chest Pain
☐	☐	Palpitations
☐	☐	Swelling of Extremities

Submit

Gastrointestinal:

YES	NO	
☐	☐	Black Tarry Stools
☐	☐	Chronic Diarrhea
☐	☐	Constipation
☐	☐	Heartburn
☐	☐	Nausea
☐	☐	Rectal Bleeding
☐	☐	Vomiting
☐	☐	Ulcers

Genitourinary:

YES	NO	
☐	☐	Blood in Urine
☐	☐	Difficulty Emptying Bladder
☐	☐	Flank Pain
☐	☐	Frequency Leaking Urine
☐	☐	Painful Intercourse
☐	☐	Painful Urination
☐	☐	Urgency

Musculoskeletal:

YES	NO	
☐	☐	Joint Pain
☐	☐	Joint Stiffness
☐	☐	Muscle Cramps
☐	☐	Muscle Pain

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Name: _____ Date of Birth: _____

Neurological:

YES	NO	
☐	☐	Dizziness
☐	☐	Numbness
☐	☐	Seizures
☐	☐	Tingling
☐	☐	Tremors
☐	☐	Weakness in Extremities

Psychiatric:

YES	NO	
☐	☐	Anxiety
☐	☐	Depression
☐	☐	Insomnia
☐	☐	Memory Loss

Endocrine:

YES	NO	
☐	☐	Decrease Sex Drive
☐	☐	Excessive Urination

Hematology:

YES	NO	
☐	☐	Anemia
☐	☐	Easy Bruising
☐	☐	Enlarged Lymph Nodes
☐	☐	Excessive Bleeding
☐	☐	Immunosuppresssed
☐	☐	History of Blood Transfusions

I affirm that I have provided all information requested by the office of Michael D. Myers, MD and that all information is true and correct to the best of my knowledge.

_____ _____

Patient or Guardian Signature Date/Time

_____ _____

Providers Signature Date/Time

Submit