Mountain View Medical Group

Partner's in Women's Health

Review Of Systems

Name:_____ Date of Birth: _____ Today's Date: _____

Any Specific problems you would like to discuss today?

_____

List Medications and Doses:

_____

_____

Pharmacy Name and Location: _____

List any Allergies to Medications: _____

Are you Allergic to Latex? Yes / No

When was your Last Menstrual Period? _____

How long do your periods last? _____

How often do you have your period? _____

What form of birth control are you using? _____

How do you wish to be addressed? _____

How did you hear about our office? _____

Has your husband/partner had a vasectomy? Yes/ No

Circle the Appropriate Response for the following Symptoms in the last year:

- Night Sweats…… Never Occasionally Frequently
- Hot Flashes…… Never Occasionally Frequently
- Severe cramps with your periods…….... Never Occasionally Frequently
- Lose urine with coughing or sneezing…….. Never Occasionally Frequently
- Depression or anxiety before your periods?....Never Occasionally Frequently
- Vaginal itching or burning……....Never Occasionally Frequently
- Vaginal Discharge……....Never Occasionally Frequently

Current Medical Problems:

_____

_____

Do you have a History of abnormal Pap Smears? Yes / No

How many Pregnancies have you had?

_____

How many Vaginal Births?_____

How many C-Sections?_____

List any Previous Surgeries:

_____

_____

Hospitalizations in the past year?

_____

Any Family History of Breast Cancer?

Yes / No Who?_____Age?_____

Any Family History of Ovarian Cancer? Yes / No

Who?_____ Age? _____

Are you married? Yes / No

Spouse or Significant Other's Name:_____

What is your Occupation?

_____

Religious Preference?_____

Do you smoke? Yes / No

How much?_____

Do you drink Alcoholic beverages?

Yes / No How Much?_____

When was your last Pap Smear?/Results?_____

When was your last Colonoscopy?/Results?

_____

When was your last Mammogram?/Results?_____

THANK YOU!!!

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