Mark E. Richey, Medical Doctor, OB-GYN
Review of Systems

Name: _____ DOB: _____ Date: _____

Please take a moment to complete the following questions. It will help us keep current on very important health issues affecting you and provide the most efficient use of your time with the doctor.

Reason for Visit: _____

Allergies □ No □ Yes
If yes indicate:
_____
_____

Medications (Name and Dosage)
_____
_____
_____
_____

Pharmacy Name/Location/Phone Number
_____
_____
_____

General
Weight Gain □ No □ Yes
Weight Loss □ No □ Yes

Skin
Hair Loss □ No □ Yes
Rash □ No □ Yes

HEENT
Headache □ No □ Yes
Bleeding Gums □ No □ Yes

Respiratory
Chronic Cough □ No □ Yes
Difficulty Breathing □ No □ Yes

Breast
Breast Mass □ No □ Yes
Breast Pain □ No □ Yes
Breast Swelling □ No □ Yes
Nipple Discharge □ No □ Yes
Nipple Pain □ No □ Yes
Recent Breast Size Changes □ No □ Yes
Skin Changes □ No □ Yes

Gastrointestinal
Bloody Stool □ No □ Yes
Incontinence of Stool □ No □ Yes
Rectal Bleeding □ No □ Yes

Female Genitourinary
Absence of Menstruation □ No □ Yes
Discharge □ No □ Yes
Excessive Menstrual Bleeding □ No □ Yes
Incontinence □ No □ Yes
Menstrual Irregularities □ No □ Yes
Painful Intercourse □ No □ Yes
Painful Menstruation □ No □ Yes
Painful Urination □ No □ Yes
Urgency □ No □ Yes
Urinary Retention □ No □ Yes
Vaginal Discharge □ No □ Yes
Vaginal Dryness □ No □ Yes
Vaginal itching/burning □ No □ Yes
Urine Leakage □ No □ Yes
Have you had an STD? □ No □ Yes
(If yes, which disease?) _____
Do you wish STD testing? □ No □ Yes

Psychiatric
Anxiety □ No □ Yes
Depression □ No □ Yes
Suicidal Ideation □ No □ Yes

Endocrine
Hot Flashes □ No □ Yes
Libido Change □ No □ Yes
Sexual Dysfunction □ No □ Yes

Hematology
Abnormal Bleeding □ No □ Yes
Excessive Bleeding □ No □ Yes

LMP: _____
(Last Menstrual Period)