Rutland Women's Healthcare
A Department of Rutland Regional Medical Center

Patient Review of Systems

❒ **New Patient**
❒ **Returning Patient**

Patient Name: ______________________________ **DOB:** ________________

Instructions:
All patients please complete Patient Review of Systems at every visit.
New patients, please also complete the Menstrual, Pregnancy & Menopause History.
Returning patients, please update the Menstrual, Pregnancy & Menopause History.

General Health:	❒ No problem	❒ Weight loss ❒ Fatigue	❒ Weight gain ❒ Other concerns:	❒ Fever
Eyes:	❒ No problem	❒ Vision change ❒ Other concerns:	❒ Glasses/Contacts	
Ears, Nose, Throat, Mouth:	❒ No problem	❒ Ulcers ❒ Headache	❒ Sinusitis ❒ Other concerns:	❒ Ringing in ears
Heart & Blood Vessels:	❒ No problem	❒ Chest pain ❒ Swelling ❒ Other Concerns:	❒ Shortness of breath with activity	❒ Shortness of breath when lying flat
Lungs & Breathing:	❒ No problem	❒ Blood in sputum ❒ Wheezing	❒ Shortness of breath ❒ Other concerns:	❒ Cough
Stomach & Bowels:	❒ No problem	❒ Bloody stool ❒ Other concerns:	❒ Nausea/vomiting ❒ Diarrhea	❒ Constipation
Kidneys, Bladder & Reproductive:	❒ No problem	❒ Urgency ❒ Leaking urine ❒ Incomplete emptying	❒ Frequency ❒ Abnormal bleeding ❒ Painful sexual intercourse	❒ Painful urination ❒ Blood in urine ❒ Other concerns:
Muscles & Bones:	❒ No problem	❒ Muscle weakness ❒ Other concerns:		
Skin:	❒ No problem	❒ Sores ❒ Other concerns:	❒ Rash	
Breasts:	❒ No problem	❒ Pain ❒ Other concerns:	❒ Discharge	❒ Lumps or Masses
Neurological:	❒ No problem	❒ Dizziness ❒ Fainting	❒ Seizures ❒ Other concerns:	❒ Numbness
Psychiatric:	❒ No problem	❒ Depression ❒ Other concerns:		
Gland, Hormones & Immune Disorders	❒ No problem	❒ Hypothyroid ❒ Diabetes	❒ Hyperthyroid ❒ Other concerns:	❒ Hot flashes
Blood & Lymph System:	❒ No problem	❒ Bruises ❒ Other concerns:	❒ Bleeding	❒ Swollen glands

If you identified a symptom or condition in a system not usually managed by an OB/GYN physician, have you reported it to your PCP? ❒ Yes ❒ No

Are you currently receiving treatment? ❒ Yes ❒ No

Patient Signature: ____ Date/Time: ___________________

*Please indicate name & relationship if other than patient: ____

Physician Review: ____ Date/Time: ___________________

Form #4552 Created 10/14 Rev 2/17, 12/17, 2/18, 7/18 *4552 & 4558 were combined 2/17

Rutland Regional Medical Center
www.RRMC.org | 160 Allen Street, Rutland, VT | 802.775.7111

Patient Label

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Menstrual, Pregnancy and Menopause History

❒ **New Patient**
❒ **Returning Patient**

Patient Name: ______________________________ **DOB:** _________________

Menstrual History:
How old were you when you started your periods?
How many days in your cycles (beginning of one cycle to beginning of next)?
How many days does your period usually last?
How heavy is the flow usually? ❒ Heavy ❒ Moderate ❒ Light ❒ Varies
Sexual Partners? ❒ Male ❒ Female ❒ Both
Contraception Methods Used:

Pregnancy History
What is the total number of times you've been pregnant?
Number of babies born full term (38-41 weeks)?
Number of babies born pre-term (less than 38 weeks)?
How many weeks gestation for pre-term baby or babies?
Number of miscarriages?
Number of abortions?
Complications of pregnancy, delivery or postpartum:

Menopause History:	
Age or Date of last menses or period?	
Hormone therapy used? ❒ Yes ❒ No ❒ What type?	
If you identified a symptom or condition in a system not usually managed by an OB/GYN physician, have you reported it to your PCP? ❒ Yes ❒ No	Are you currently receiving treatment? ❒ Yes ❒ No

Patient Signature: ____ Date/Time: ____________________

*Please indicate name & relationship if other than patient: ____

Physician Review: ____ Date/Time: ____________________

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