



**FEMALE SYMPTOM CHECKLIST**

**In the last month, have you had problems with:**

**Yes No CONSTITUTIONAL / GENERAL:**

- Fatigue
- Fever
- Night Sweats

**Yes No HEENT: EYES**

- Eye Discharge
- Visual Loss

**Yes No HEENT: EARS**

- Discharge
- Hearing Loss

**Yes No HEENT: NOSE & SINUS**

- Nasal Drainage

**Yes No RESPIRATORY / THORAX**

- Cough
- Dyspnea (shortness of breath)
- Wheezing (whistling sound when breathing)

**Yes No CARDIAC**

- Chest Pains (Cardiac)
- Irregular Heartbeat / Palpitations (Rapid)

**Yes No VASCULAR**

- Claudication (leg cramps with exercise)

**Yes No GASTROINTESTINAL:**

- Abdominal Pain
- Constipation
- Diarrhea
- Vomiting

**Yes No GENITOURINARY:**

- Dysuria (painful urination)
- Hematuria (bloody urine)

MRN:

Name:

DOB:

Date:

*NG ROS Female—Default only.doc*

- Yes No REPRODUCTIVE: FEMALE**
- Dysmenorrhea (painful periods)
  - Menorrhagia (unusually heavy/long periods)

- Yes No REPRODUCTIVE: GENERAL**
- Vaginal Discharge

- Yes No METABOLIC / ENDOCRINE:**
- Cold Intolerance
  - Heat Intolerance
  - Polydipsia (excessive thirst)
  - Polyphagia (excessive eating)
  - Polyuria (producing large volumes urine)

- Yes No NEUROLOGICAL:**
- Gait Disturbance (difficulty walking)

- Yes No PSYCHIATRIC:**
- PSYCHIATRIC (Anxiety / Depression)

- Yes No DERMATOLOGIC:**
- Pruritis (intense itching sensation)
  - Rash

- Yes No MUSCULOSKELETAL:**
- Bone / Joint Symptoms
  - Muscle Weakness

- Yes No HEMATOLOGIC:**
- Easy Bleeding
  - Easy Bruising

- Yes No IMMUNOLOGICAL:**
- Environmental Allergies
  - Food Allergies