OBSTETRIX MEDICAL GROUP

Patient Name:_____
Social Security Number:_____
Date:_____

Review of Systems Questionnaire

Do you or have you taken any medication in the last year:

Medications Taken	Date Taken

Do you have any known allergies?

Do you currently smoke?
□ Yes □ No

Do you have or have you had any of the following conditions:

Yes	No	Unsure	Unexplained fever
Yes	No	Unsure	Vision problems
Yes	No	Unsure	Hearing loss
Yes	No	Unsure	Ear Infections (Other than childhood)
Yes	No	Unsure	Sinus problems
Yes	No	Unsure	Repeated nosebleeds
Yes	No	Unsure	Long term sore throat
Yes	No	Unsure	Pneumonia
Yes	No	Unsure	Asthma
Yes	No	Unsure	Close contact with person(s) with tuberculosis
Yes	No	Unsure	Tuberculosis vaccine (BCC)

Yes	No	Unsure	Positive tuberculosis skin test
Yes	No	Unsure	Unexplained cough
Yes	No	Unsure	Unexplained shortness of breath
Yes	No	Unsure	Other lung problems
Yes	No	Unsure	Heart murmur
Yes	No	Unsure	Mitral valve prolapse
Yes	No	Unsure	Other heart valve problems
Yes	No	Unsure	Heart attack
Yes	No	Unsure	Heart disease
Yes	No	Unsure	Unexplained chest pains
Yes	No	Unsure	Unexplained fainting
Yes	No	Unsure	Irregular heart beat
Yes	No	Unsure	Other heart problems
Yes	No	Unsure	High blood pressure in pregnancy
Yes	No	Unsure	High blood pressure, other
Yes	No	Unsure	Raynaud's disease, Raynaud's phenomenon
Yes	No	Unsure	Poor blood circulation
Yes	No	Unsure	Severe nausea and vomitting in pregnancy
Yes	No	Unsure	Severe nausea and vomitting before pregnancy
Yes	No	Unsure	Intestinal problems (irritable colon, chron's disease, etc.)
Yes	No	Unsure	Dietary restrictions
Yes	No	Unsure	Unexplained recurring diarrhea
Yes	No	Unsure	Constipation problem
Yes	No	Unsure	Heartburn, reflux
Yes	No	Unsure	Hepatitis, yellow jaundice
Yes	No	Unsure	Liver problems
Yes	No	Unsure	Bladder or kidney infections
Yes	No	Unsure	Kidney stones
Yes	No	Unsure	Problems with urine
Yes	No	Unsure	Menstrual problems
Yes	No	Unsure	Infertility, difficulty getting pregnant
Yes	No	Unsure	Vaginal infections
Yes	No	Unsure	Herpes or a partner with herpes
Yes	No	Unsure	Sexually transmitted disease
Yes	No	Unsure	Pelvic inflammatory disease
Yes	No	Unsure	Gonorrhea
Yes	No	Unsure	Chlamydia
Yes	No	Unsure	Syphilis
Yes	No	Unsure	Genital warts
Yes	No	Unsure	HIV infection, AIDS or a partner with HIV / AIDS

Yes	No	Unsure	Abnormal pap smears
Yes	No	Unsure	Diabetes (high blood pressure)
Yes	No	Unsure	Thyroid problems
Yes	No	Unsure	Other hormone problems
Yes	No	Unsure	Epilepsy, seizure disorder
Yes	No	Unsure	Unexplained drowsiness
Yes	No	Unsure	Migraine / cluster headaches
Yes	No	Unsure	Other recurring headaches
Yes	No	Unsure	Depression
Yes	No	Unsure	Panic attack disorder
Yes	No	Unsure	Psychiatric / mental / emotional problems
Yes	No	Unsure	Skin problems
Yes	No	Unsure	Unexplained hair loss
Yes	No	Unsure	Arthritis / joint pain
Yes	No	Unsure	Lupus
Yes	No	Unsure	Rheumatic fever
Yes	No	Unsure	Blood transfusions
Yes	No	Unsure	Bleeding tendency
Yes	No	Unsure	Blood clots, thrombophlebitis
Yes	No	Unsure	Rh Sensitized
Yes	No	Unsure	Any past surgeries (if yes, please list below)
Yes	No	Unsure	Any known allergies

Past surgeries:_____

_____

_____

_____

_____

Comments_____

_____

_____

_____

_____

_____

Reviewed by: _____