Obstetrical Associates

CM ________________

Review of Systems

Name:	DOB: / /	Date: / /

Please check (√) the appropriate box(es) if you have experienced, either recently or within the last year, any of the following symptoms or conditions.

System	Symptoms
1. Constitutional	☐ **None** ☐ Weight Loss ☐ Weight Gain ☐ Fever ☐ Fatigue ☐ Loss of Appetite ☐ Other ____
2. Eyes	☐ **None** ☐ Vision Change ☐ Glasses/Contacts ☐ Dryness ☐ Discharge ☐ Other ____
3. Ears, Nose & Throat	☐ **None** ☐ Hearing Loss ☐ Sinusitis ☐ Headache ☐ Ulcers ☐ Sore Throat/Hoarseness ☐ Other ____
4. Cardiovascular	☐ **None** ☐ Palpitation ☐ Chest Pain ☐ Swelling ☐ Difficulty Breathing with exertion ☐ Difficulty Breathing While Lying Down ☐ Varicose Veins ☐ Spider Veins ☐ Hemorrhoids ☐ Other ____
5. Respiratory	☐ **None** ☐ Wheezing ☐ Coughing Blood ☐ Persistent Cough ☐ Shortness of Breath ☐ Other ____
6. Gastrointestinal	☐ **None** ☐ Constipation ☐ Bloody Stool ☐ Diarrhea ☐ Pain ☐ Flatulence ☐ Nausea/Vomiting/Indigestion ☐ Other ____
7. Genitourinary	☐ **None** ☐ Urinary Urgency ☐ Urinary Frequency ☐ Urinary Incontinence ☐ Painful Urination ☐ Blood in Urine ☐ Incomplete Voiding ☐ Abnormal or Painful Periods ☐ Abnormal Vaginal Bleeding ☐ PMS ☐ Vaginal/Vulvar Lesion ☐ Bulge in Vagina ☐ Pelvic Pressure ☐ Vaginal/Vulvar Itching ☐ Vaginal Discharge ☐ Odor ☐ Other ____
8. Muskuloskeletal	☐ **None** ☐ Muscle or Joint Pain ☐ Muscle Weakness ☐ Other ____
9a. Skin	☐ **None** ☐ Dry/Itchy Skin ☐ Pigmented Lesions ☐ Rash ☐ Ulcers ☐ Other ____
9b. Breast	☐ **None** ☐ Pain ☐ Nipple Discharge ☐ Mass ☐ Other ____
10. Neurologic	☐ **None** ☐ Seizures ☐ Numbness ☐ Difficulty Walking ☐ Loss of Consciousness ☐ Balance Problem ☐ Memory Problems ☐ Dizziness ☐ Other ____
11. Psychiatric	☐ **None** ☐ Depression ☐ Anxiety ☐ Mood Swings ☐ Irritability ☐ Other ____
12. Endocrine	☐ **None** ☐ Hair Loss ☐ Hot Flashes ☐ Hot/Cold Intolerance ☐ Frequent Thirst ☐ Frequent Hunger ☐ Loss of Appetite ☐ Frequent Urination ☐ Other ____
13. Hematologic/ Lymphatic	☐ **None** ☐ Bruising ☐ Bleeding ☐ Swollen Glands ☐ Swelling in Hands/Feet ☐ Other ____
14. Allergic/ Immunologic	☐ **None** ☐ Sneezing ☐ Nasal Congestion ☐ Watery/Itchy Eyes ☐ Other ____

IN CASE OF EMERGENCY, WHO SHOULD WE CONTACT?

NAME: ____________________ RELATIONSHIP: ____________________

ADDRESS: ____________________ PHONE: ( ) ____________________

INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS AND INFORMATION RELEASE

I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim.

I request that any payment of authorized benefits be made on my behalf. I assign the benefits payable to which I am entitled, including Medicare and private insurance and other health plans, to Obstetrical Associates.

This agreement will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as The original. <u>I understand that I am financially responsible for all charges whether or not paid by said insurance.</u>

Signed: ____________________ Date: ____________________