Consultants in Women's Healthcare
Washington University Clinical Associates

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# YEARLY REVIEW OF SYMPTOMS

| **APPOINTMENT DATE**: | **DATE OF BIRTH**: |
|---|---|

**PATIENT NAME** (*last, first, M.I.*):

**PRONOUNS**: ___She/Her ___He/Him ___They/Them ___Other:

**PRIMARY REASON FOR VISIT**: *check more than one if appropriate*

___Well woman visit ___New problem ___Follow-up on existing problem

**Would you like a chaperone for your visit?** ___Yes ___No

Please check any of the following problems you are currently experiencing or have experienced **within the past 30 days**.

| | | | |
|---|---|---|---|
| ___fevers | ___vomiting | ___pain with sexual activity | ___chills |
| ___constipation | ___muscle pain | ___weight loss (unplanned) | ___diarrhea |
| ___headaches | ___fatigue | ___pain with urination | ___dizziness |
| ___weakness | ___leakage of urine | ___depressed mood | ___chest pain |
| ___painful periods | ___anxiety | ___shortness of breath | ___heavy periods |
| ___memory loss | ___nausea | ___irregular periods | ___abdominal / pelvic pain |

Other problems you have experienced in the past 30 days that are not listed above:

PLEASE LIST ANY SURGERIES, PROCEDURES, OR CHANGES TO YOUR PERSONAL OR YOUR FAMILY MEDICAL HISTORY IN THE PAST 12 MONTHS

| | |
|---|---|
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| | |
| | |

**Do you feel safe in your own home?** ___Yes ___No - Explain:

**Are there concerns about emotional, physical, sexual, or verbal abuse you wish to speak to the provider about today?** ___Yes ___No

*Office use only*
___ all other systems negative