Date: _____ Chart #: _____

OB/GYN PROFESSIONALS OF EAST TENNESSEE, P.C.

REVIEW OF SYSTEMS (Please list any problems under the following)

1. Eyes, Ears, Throat:	_____ None	_____ If Yes, Explain:
2. Thyroid:	_____ None	_____ If Yes, Explain:
3. Diabetes:	_____ None	_____ If Yes, Explain:
4. Heart, Vessels:	_____ None	_____ If Yes, Explain:
5. Lungs, Chest:	_____ None	_____ If Yes, Explain:
6. Stomach, Abdomen:	_____ None	_____ If Yes, Explain:
7. Kidneys, Bladder:	_____ None	_____ If Yes, Explain:
8. Breasts:	_____ None	_____ If Yes, Explain:
9. Genital Area:	_____ None	_____ If Yes, Explain:
10. Legs, Feet:	_____ None	_____ If Yes, Explain:
11. Arms, Hands:	_____ None	_____ If Yes, Explain:
12. Nerves:	_____ None	_____ If Yes, Explain:
13. Brain, Nervous System:	_____ None	_____ If Yes, Explain:
14. Sleep Problems:	_____ None	_____ If Yes, Explain:

Did you fill out this form by yourself? Yes _____ No _____

Signature: _____ Date: _____

Did you have help? Yes _____ No _____ By whom? _____

Helper's Signature: _____ Date: _____

Reviewed by: _____ Date: _____