Review of Systems

Patient Name: ____________ Date of Birth: ______________ Today's Date: ____________

Preferred Pharmacy Name & Number: ______________________________

Please select the below genitourinary symptoms you are currently experiencing:

☐ Decreased Libido ☐ Night Time Urination ☐ Orgasm Difficulties ☐ Painful Intercourse

☐ Painful Urination ☐ Urinary Frequency ☐ Urinary Loss ☐ Vaginal Discharge

☐ Vaginal Dryness ☐ Vaginal Laxity

Please select symptoms below that you are CURRENTLY experiencing.

CONSTITUTIONAL: ☐ Fever ☐ Chills ☐ Weight Loss

EYES: ☐ Cataracts ☐ Glaucoma

CARDIOVASCULAR: ☐ Chest Pain ☐ Irregular Heart Beat

RESPIRATORY: ☐ Cough ☐ Shortness of Breath ☐ Wheezing

GASTROINTESTINAL: ☐ Abdominal Pain ☐ Nausea ☐ Heartburn ☐ Vomiting

MUSCULOSKELETAL: ☐ Muscle Pain ☐ Joint Pain

ENDOCRINE: ☐ Excessive Thirst

MUSCULOSKELETAL: ☐ Limitation of Motion in Upper Extremities

ENDOCRINE: ☐ Excessive Thirst

HEME-LYMPH: ☐ Blood Clotting Problems ☐ Swollen Glands

ALLERGIC-IMMUNOLOGIC: ☐ Drug Allergies ☐ Seasonal Allergies

Do you have a Living Will: ☐ Yes ☐ No If yes, please include name: ________________