<table>
<thead>
<tr>
<th><strong>Comprehensive Review of Systems</strong></th>
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<td><em>(Please circle Yes or No)</em></td>
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**Name: ________________________________**

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<tr>
<th><strong>Constitutional</strong></th>
<th><strong>Genitourinary Female</strong></th>
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<td>Weight change</td>
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<td>Loss of appetite</td>
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<td>Weakness</td>
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<td>Night sweats</td>
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<td>Breast feeding (if applicable)</td>
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<tr>
<th><strong>Dermatology</strong></th>
<th><strong>Premenstrual Syndrome</strong></th>
<th><strong>Infertility</strong></th>
<th><strong>Dysmenorrhea</strong></th>
<th><strong>Frequent yeast infections</strong></th>
<th><strong>Vaginal itching</strong></th>
<th><strong>Intermenstrual bleeding</strong></th>
<th><strong>Pelvic pain</strong></th>
<th><strong>Sexual activity</strong></th>
<th><strong>Irregular periods</strong></th>
<th><strong>Abnormal vaginal discharge</strong></th>
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<th><strong>ENT</strong></th>
<th><strong>Eye irritation</strong></th>
<th><strong>Drainage from eyes</strong></th>
<th><strong>Blurring of Vision</strong></th>
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<td>Nose bleeds</td>
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<th><strong>Respiratory</strong></th>
<th><strong>Excessive thirst</strong></th>
<th><strong>Excessive sweating</strong></th>
<th><strong>Excessive urination</strong></th>
<th><strong>Cold intolerance</strong></th>
<th><strong>Heat intolerance</strong></th>
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<td>Shortness of breath</td>
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<th><strong>Easy bruising</strong></th>
<th><strong>Swollen glands</strong></th>
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<th><strong>Leg cramps</strong></th>
<th><strong>Joint pain</strong></th>
<th><strong>Joint swelling</strong></th>
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<th><strong>Neck pain</strong></th>
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<th><strong>Difficulty urinating</strong></th>
<th><strong>Blood in urine</strong></th>
<th><strong>urinary urgency</strong></th>
<th><strong>Frequent urination</strong></th>
<th><strong>Urinary incontinence</strong></th>
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<tbody>
<tr>
<td>Difficulty urinating</td>
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<td>Blood in urine</td>
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<td>Chest pains</td>
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<td>High blood Pressure</td>
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