



**FLORIDA
GYNECOLOGIC
ONCOLOGY**

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RETURN PATIENT VISIT

Name: _____ Age: _____ Date: _____

Patient E-mail Address: _____

Why did you come to see the doctor today? _____

Have **you** developed any **new** medical problems since your last visit? Yes No

If yes, please list: _____

List **all** current medications: _____

Has your **family** developed any **new** medical problems since your last visit? Yes No

If yes, please list: _____

REVIEW OF SYSTEMS (please check all that apply to you today)

- | | | | |
|-------------------------|---------------------------------|---|---|
| Skin | <input type="checkbox"/> Normal | <input type="checkbox"/> Rash | <input type="checkbox"/> Ulcers |
| Neurological | <input type="checkbox"/> Normal | <input type="checkbox"/> Seizures | <input type="checkbox"/> Neuropathy |
| | | <input type="checkbox"/> Syncope / Pass Out | |
| Psychiatric | <input type="checkbox"/> Normal | <input type="checkbox"/> Depression | |
| Endocrine | <input type="checkbox"/> Normal | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Hot Flashes |
| Urinary | <input type="checkbox"/> Normal | <input type="checkbox"/> Blood in Urine | <input type="checkbox"/> Pain on Urination |
| | | <input type="checkbox"/> Leakage of Urine | <input type="checkbox"/> Urgency to Void |
| Genital | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> Vaginal Discharge <input type="checkbox"/> Breast Pain |
| Sex Function | <input type="checkbox"/> Normal | <input type="checkbox"/> Painful Intercourse | <input type="checkbox"/> Bleeding after Intercourse <input type="checkbox"/> Lack of Desire |
| Hematology | <input type="checkbox"/> Normal | <input type="checkbox"/> Easy Bruising | <input type="checkbox"/> Spontaneous Bleeding |
| | | <input type="checkbox"/> Enlarged Lymph Nodes | |
| Allergy | <input type="checkbox"/> Normal | <input type="checkbox"/> Seasonal Allergies | <input type="checkbox"/> Drug Allergies |
| General | <input type="checkbox"/> Normal | <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Fatigue |
| Eyes | <input type="checkbox"/> Normal | <input type="checkbox"/> Change in Vision | |
| Ears/Mouth | <input type="checkbox"/> Normal | <input type="checkbox"/> Problems Hearing | <input type="checkbox"/> Ulcers <input type="checkbox"/> Sore Throat |
| Cardiovascular | <input type="checkbox"/> Normal | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Shortness of Breath with Exercise |
| | | <input type="checkbox"/> Shortness of Breath in Bed | |
| Respiratory | <input type="checkbox"/> Normal | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Wheezing |
| | | <input type="checkbox"/> Respiratory Infection (cold) | |
| Gastrointestinal | <input type="checkbox"/> Normal | <input type="checkbox"/> Nausea/Vomiting | <input type="checkbox"/> Diarrhea <input type="checkbox"/> Blood Stools |
| Musculoskeletal | <input type="checkbox"/> Normal | <input type="checkbox"/> Muscle Weakness | <input type="checkbox"/> Arthritis |

HealthCare Screening Tests: (please list date and result of most recent test)

Pap Test: _____ Mammogram: _____ Colorectal Screen: _____

Date of LMP: _____

Patient Signature: _____ Date: _____