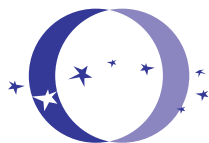

FLORIDA GYNECOLOGIC ONCOLOGY

James W. Orr, Jr., M.D.
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Denyse M. Mahoney, P.A.-C

Megan Tetlow, P.A.-C

RETURN PATIENT VISIT

Name: ______________________ Age: ________ Date: ____________

Patient E-mail Address: ______________________________

Pharmacy Name: ______________________ Phone Number: ____________

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: ______________________________

____

Name of Primary Care Physician: ______________________________

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

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

Pap Test: ____________ Mammogram: ____________ Colonoscopy: ____________

Patient Signature: ______________________ Date: ____________