William J. Moss, M.D., F.A.C.O.G.

GYN HISTORY SINCE YOUR LAST VISIT

Name: _____ Birth Date: ___/___/___

Phone: _____ Cell: _____ Today's Date: ___/___/___

WHAT ARE YOU HERE FOR TODAY? PLEASE CHECK ONE _____YEARLY EXAM. _____PROBLEM

IF PROBLEM, PLEASE SUMMARIZE. _____

SINCE YOUR LAST OFFICE VISIT HAVE YOU BEEN OR EXPERIENCED ANY OF THE FOLLOWING, PLEASE ANSWER..

OPERATIONS/HOSPITALIZATIONS

Reason	Date	TYPE	Date
1)		1)	
2)		2)	
3)		3)	

WHAT CURRENT MEDICATIONS DO YOU TAKE

Drug Name	Dosage	Drug Name	Dosage
1)		4)	
2)		5)	
3)		6)	

HAVE YOU EXPERIENCED AN ALLERGIC REACTION TO MEDICATION OR FOOD?	YES____ NO_____	WHAT MEDICATION OR FOOD? _____ _____ _____	Type of reaction? _____ Date when this Occurred?_____

REVIEW OF SYSTEMS

PLEASE CHECK (X) IF ANY OF THE FOLLOWING APPLY TO YOU NOW, IN THE PAST OR OFTEN

1. CONSTITUTIONAL	CURRENTLY	PAST	NOTES:
Weight loss	☐	☐	
Weight gain	☐	☐	
Fever	☐	☐	
Fatigue	☐	☐	
2. EYES			
Double vision	☐	☐	
Spots before eyes	☐	☐	
Vision changes	☐	☐	
3. ENT/MOUTH			
Ear aches	☐	☐	
Ringing in ears	☐	☐	
Sinus problems	☐	☐	
Sore throat	☐	☐	
Mouth sores	☐	☐	
Dental problems	☐	☐	
4. CARDIOVASCULAR			
Painful breathing	☐	☐	
Chest pain	☐	☐	
Difficult breathing - - on exertion - - -	☐	☐	
Swelling of legs	☐	☐	
Palpitations of heart	☐	☐	
5. RESPIRATORY			
Wheezing	☐	☐	
Spitting up blood	☐	☐	
Shortness of breath	☐	☐	
Cough, chronic	☐	☐	
6. GASTROINTESTINAL			
Diarrhea, frequent	☐	☐	
Bloody stool	☐	☐	
Nausea/vomiting	☐	☐	
Constipation	☐	☐	

7. GENITOURINARY	CURRENTLY	PAST	NOTES:
Blood in urine	☐	☐	
Pain with urination	☐	☐	
Urgency	☐	☐	
Frequency of urination	☐	☐	
Incomplete emptying	☐	☐	
Stress incontinence	☐	☐	
Abnormal periods	☐	☐	
Painful intercourse	☐	☐	
8. MUSCULOSKELETAL			
Muscle weakness	☐	☐	
9. SKIN/BREAST			
Pain in breast	☐	☐	
Discharge	☐	☐	
Masses	☐	☐	
Rash	☐	☐	
Ulcers	☐	☐	
10. NEUROLOGICAL			
Dizziness	☐	☐	
Seizures	☐	☐	
Numbness	☐	☐	
Trouble walking	☐	☐	
11. PSYCHIATRIC			
Depression	☐	☐	
Crying, frequent	☐	☐	
12. ENDOCRINE			
Dry skin	☐	☐	
Abnormal thirst	☐	☐	
Hot flashes	☐	☐	

Completed by: Patient ☐ Office Nurse ☐ Physician ☐

Signature of patient: _____ Date: _____