Florida Specialists In Urology System Review

A Division of 21st Century Oncology LLC

PATIENT NAME:______________________________ DATE:______________

Do you now or have you had any problems related to the following systems? Check **Yes** or **No**
Please explain any **Yes** answers in space provided.

Constitutional Symptoms
Yes ☐ No ☐ Fever
Yes ☐ No ☐ Chills
Yes ☐ No ☐ Headache
Other______________

Eyes
Yes ☐ No ☐ Blurred Vision
Yes ☐ No ☐ Double Vision
Yes ☐ No ☐ Cataracts
Yes ☐ No ☐ Glaucoma
Yes ☐ No ☐ Pain
Other______________

Allergic/Immunologic
Yes ☐ No ☐ Hay Fever
Yes ☐ No ☐ Drug Allergies
Other______________

Neurological
Yes ☐ No ☐ Headaches
Yes ☐ No ☐ Black Outs
Yes ☐ No ☐ Seizures
Yes ☐ No ☐ Stroke
Yes ☐ No ☐ Tremor
Yes ☐ No ☐ Dizzy Spells
Yes ☐ No ☐ Numbness/Tingling
Yes ☐ No ☐ Depression
Other______________

Endocrine
Yes ☐ No ☐ Diabetes
Yes ☐ No ☐ Thyroid Trouble
Yes ☐ No ☐ Excessive Thirst
Yes ☐ No ☐ Too Hot/Cold
Yes ☐ No ☐ Tired/Sluggish
Other______________

Cardiovascular
Yes ☐ No ☐ Chest Pain
Yes ☐ No ☐ Varicose Veins
Yes ☐ No ☐ High Blood Pressure
Yes ☐ No ☐ Irregular Heartbeat
Yes ☐ No ☐ Heart Attack
Yes ☐ No ☐ Heart Operations
Yes ☐ No ☐ Blood Vessel Problems
Other______________

Abdomen
Yes ☐ No ☐ Pain
Yes ☐ No ☐ Ulcers
Yes ☐ No ☐ Gallbladder Trouble
Yes ☐ No ☐ Colitis
Yes ☐ No ☐ Blood In Stools
Yes ☐ No ☐ Diverticulitis
Yes ☐ No ☐ Jaundice
Yes ☐ No ☐ Liver Problems
Other______________

Integumentary
Yes ☐ No ☐ Skin Rash
Yes ☐ No ☐ Boils
Yes ☐ No ☐ Persistent Itch
Other______________

Musculoskeletal
Yes ☐ No ☐ Joint Pain
Yes ☐ No ☐ Neck Pain
Yes ☐ No ☐ Back Pain
Yes ☐ No ☐ Arthritis
Yes ☐ No ☐ Gout
Other______________

Ear/Nose/Throat/Mouth
Yes ☐ No ☐ Hearing Problems
Yes ☐ No ☐ Ear Infection
Yes ☐ No ☐ Throat Problems
Yes ☐ No ☐ Sinus Problems
Other______________

Genitourinary
Yes ☐ No ☐ Infection
Yes ☐ No ☐ Stones
Yes ☐ No ☐ Blood In Urine
Yes ☐ No ☐ Urine Leakage
Yes ☐ No ☐ Urine Retention
Yes ☐ No ☐ Painful Urination
Yes ☐ No ☐ Urinary Frequency
Yes ☐ No ☐ Prostate Surgery
Other______________

Respiratory
Yes ☐ No ☐ Wheezing
Yes ☐ No ☐ Frequent Cough
Yes ☐ No ☐ Shortness of Breath
Other______________

Hematologic/Lymphatic
Yes ☐ No ☐ Anemia
Yes ☐ No ☐ Leukemia
Yes ☐ No ☐ Unusual Bruising
Yes ☐ No ☐ Swollen Glands
Yes ☐ No ☐ Blood Clotting Problem
Yes ☐ No ☐ Blood Thinning Meds.
Other______________

Physician:______________________________ Date:______/______/______