UTSouthwestern

Medical Center SSN: XXX-XX-Review of Systems

Address:_____

Pt. Name:

Urology Outpatient Clinic Constitutional: In general, on a regular basis, are you experiencing any of the following symptoms? Nö Yes No Yes No Yes Weight Loss .Chills Fever Excessive Sweating Malaise/Fatigue Weight Gain General Weakness Skin: In general, on a regular basis, are you experiencing any of the following skin symptoms? Yes No Yes No Yes No New/Changing Lesions Rash Itching Unusual Hair Loss Head/Ears/Nose/Throat/Mouth: In general, on a regular basis, are you experiencing any of the following head, ears, nose, throat, and mouth symptoms? Yes Yes No No Yes No Ringing in the Ears Headaches **Difficulty Hearing** Nosebleeds Ear Discharge Ear Pain Difficulty Swallowing Nasal Stuffiness Snoring Sore Throat Mouth Lesions Eye: In general, on a regular basis, are you experiencing any of the following eye symptoms?

	Yes	No		Yes	No	•	Yes	No
Blurred Vision	0	0	Double Vision	0	0	Pain Looking at Bright Lights	\bigcirc	0
Eye Pain	0	0	Eye Discharge	10	0	Eye Redness	0	0

Cardiovascular: In general, on a regular basis, are you experiencing any of the following heart symptoms?

	Yes	No		Yes	No		Yes	No
Chest Pain	0	0	Palpitations	0	0	Difficulty Breathing When Lying Flat	0	0
Pain in Legs when Walking	0	0	Leg or Ankle Swelling	\bigcirc	\bigcirc	•		

Pulmonary: In general, on a regular basis, are you experiencing any of the following lung symptoms?

·	Yes	No		Yes	No		Yes	No
Cough	0	\bigcirc	Coughing Blood	0	\bigcirc	Sputum Production	\bigcirc	0
Shortness of Breath	\bigcirc		Wheezing	\bigcirc				

200	Pt. Name:Address:		
	City MRN:	State	· Zip
	DOB:		
	SSN: XXX-XX	With SALES #1, 0000074	SEX:
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	Urology	Med Outpa	ical	Cer Clinic	nter	MR DOI SSI	N: B: V: XXX	•XX			State		SEX:			
	Review of Systems															
Gastro	<u>pintestinal</u> : In g	eneral,	on a	regula	ır basis,	are you ex	perie	ncing	any o	f the	following stom	ach ar	nd inte	stinal s	sympt	oms?
			Y	es l	No				Yes	No		Yes	No			
	Heartburn		. ()	Oh.	ange in App	etite		\bigcirc	\bigcirc	Nausea	10	0	7		
	Vomiting			$\supset [$	Abo	dominal Pai	n		\bigcirc	\bigcirc	Diarrhea			.]	•	la la
	Constipation)	Blo	od in the St	tooi		\bigcirc	\bigcirc	Black Stool				13	
	Incontinence o	f Stool)												
<u>Genito</u> sympt	ourinary: In gen	eral, o	·			e you expe	erlenci	T		`	lowing sexual,	T	·	ladder	,	
			Ye	s N	0			Yes	No		· · · · · · · · · · · · · · · · · · ·	Yes	No			
	Burning when I		19 C	$) \mid C$) Urge	ncy to Urina	ate			Blo	od in Urine				•	
	Pain when Urir	nating	C	$) \mid C$		nal Discharg		0		Per	nile Discharge	0	0	_		
	Frequency in L	Jrinatio:				rience Incon ying when ting	nplete				ke from Sleep Jrinate		0.			
	Incontinence.of	f Urine	10) Sexu	al Problems	3	0	10	1						
ภับรถบ	loskeletal: In ge	eneral	onar	eline	r hasis	are vou ex	nerien	ncina :	any of	the f	ollowing musc	le and	l hone	symnte	ome?	
	roomeroser. In go					are you ex	·		<u> </u>			T	T)]	,,,,,	
		Ye	s No				Yes				 	Yes	No			
	Muscle Pain) Ne	ck Pain		10) B	ack P	ain	\cup	0			•
	Joint Pain	\perp C	$) \mid C$) Fal	ls		10)		·	<u> </u>				
nviro	nmental/Allergy:	In ge	neral,	on a r	egular l	oasis, are y	ou ex	perier	ncing	any o	f the following	symp	toms?	1		
			Yes	No			Yes	No				Yes	No			
	Environmental A	llergies	0	0	Seasor	al Allergies	0	10	Fred	uent	Thirst	0	0			
	Heat Intoleranc	e	• () .	\bigcirc	Cold In	tolerance	0	10	Abno	ormal (Bruising/Bleeding	0		ı		
eurol	ogic: In general	, on a	regula	r basi	s, are yo	ou experier	ncing	any of	the f	ollow	ng neurologic	al sym	ptoms	?		
		Yes	No					Yes	No			Yes	No			
	Dizzlness		\bigcirc	Tingli	ina			\bigcap	0	Tren	nor wange	\bigcirc	$\overline{}$			
	Numbness	$\tilde{}$	$\frac{\circ}{\circ}$		ch Chan	ge		$\overline{}$	$\stackrel{\smile}{\cap}$		s of Strength	$\stackrel{\smile}{\cap}$				
	Seizures	$\overset{\sim}{\rightarrow}$	$\stackrel{\sim}{\sim}$			ciousness		$\widetilde{\frown}$		<u> </u>			\rightarrow			
sycho	social: In gene	ral, on	a regu				lencin	g any	of the	follo	wing psycholo	gical	sympto	ms?		
		Yes	s No	1		· Ye	s N	0				Yes	No			
	Depression	1	10	Sur	stance /	Abuse	1) Ha	llucina	tions		0	7			
	Nervous/Anxiou	$\exists \preceq$	$+ \approx$		nmnia		+		mory			\rightarrow	\exists			

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Health History Questionnair	e .		50%;		<u>.</u>	en e arrende al arrende e e e e e e e e e e e e e e e e e e	
Allergies: Medication or Subs	tance				Re	action	
					•		
·	,						
Current Medications and Over-the-Co	unter	Medic	ines:				
. <u>Name</u> .			· <u>Dose</u>		•	Frequency	

Medical History:							
***************************************	Yes	No	Date First (approxin	Noted	Comments		
Allergies	\bigcirc		(approxin	nately)			
Anemia	$\stackrel{\smile}{\sim}$	0					
Angina	$\overline{0}$	Ŏ				,	
Anxiety Disorder	Ŏ	Ŏ			•		
Arthritis	Ŏ	Ŏ					
Asthma	Ŏ	Ŏ			•		
Atrial Fibrillation	Ŏ	Ŏ			V0 + 10	· · · · · · · · · · · · · · · · · · ·	
Bowel Disease	Ō	0			Fame Review		
Breast Cancer	Ö	0				:	
Colorectal Cancer	Ó	Ō					
Congestive Heart Failure	0	0					
Chronic Obstructive Pulmonary Disease (COPD)	0	0					

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Coronary Artery Disease

UT Southwestern Medical Center

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Health History Questionnaire

Medical History (continued):				
	Yes	No	Date First Noted (approximately)	Comments
Depression	0	0	1	
Diabetes Type 1	0	0		
Diabetes Type 2	0	0		
Diverticulitis	0	0		
Gallbladder Disease	0	0		
Gastric Ulcers	0	0		
GERD	0	0		
Heart Attack/MI	0	0		
Hepatitis	0	0		
High Cholesterol	0	0		
Hypertension	0	0		
Hyperthyroid Disease	0	0		
Hypothyroid Disease	0	0		
Refuses Blood Products	0	0		
Lung Cancer	. (0	,	• .
Memory Loss	0	0		
Migraines	0	0		·
Multiple Sclerosis	0	0		
Osteoporosis	\bigcirc	0		
Prostate Disease	. O		·	
Renal Disease	0	0		
Rheumatoid Arthritis	0	0		
Seizures	0	0		
Sickle Cell Anemia	0	0		
Sleep Apnea	0	0		
Strokes	\bigcirc	0		
Other:				

UTSouthwestern Medical Center

Health History Questionnaire

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14/5		. <u> </u>

Surgical History:	100			
	Yes	No	Occurrence Date (approximately)	Comments
Abdominal Aortic Aneurysm	0	0		
Appendectomy	0	0		
Back Surgery	0	0		
Bowel Surgery	0	0		
Brain Surgery	\bigcirc	0		
Breast Lumpectomy	0	0		
Breast Mastectomy	0	0		.`
Cardiac Bypass	\circ	0		·
Cardiac Catheterization	0	0		
C-Section .	\bigcirc	0		
Cosmetic Surgery	0	0		
ENT Surgery	\bigcirc	0		
Eye Surgery	0	0		
Gallbladder Surgery	0	0	,	
Heart Surgery	0	0		
Hernia Repair	0	0		
Hip Surgery	0	0		
Hysterectomy	0	0		
Kidney/Bladder Surgery	0	0		
Knee Surgery	0	0		
Lung Surgery	0	0		
Moh's Surgery	0	0		
Prostate Surgery	0	0		
Shoulder Surgery.	0	0		
Spleen Surgery	0	0	Section 2016	
Tonsillectomy	0	0		
Tubal Ligation	0	0		
Vasectomy	0	0		
Other (please specify):				·

UTSouthwestern

Medical Center

Health History Questionnaire

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amily History:																			
Relationship	Name	Status (Aliye or Deceased)	History of Alcohol or Drug Problems		Problems with Anesthesia Arthritis	Biood Diseases	Cancer	Diabetes	Genetic	Gastrojntestinal Problems	Genitourinary (GU)	Heart	Hypertension	Lipid Problems	Neurological	Psychiatric Problems	Stroke	Thyroid	Other (please specify)
other	, ,		43.5			Ages-	 							44		14 (M)			
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ster other						100		1884 1884				38.3				140.46		366	
aternal Grandmother			33%		.6.	38.850 (38.156)												100	
aternal Grandfather			9:2		\$150 0000	を開催 スペンス		36 m		***		(Signal)				224			
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aughter			16-69			7877				30.34		100 000 22 000				100 mg		200 S	
on						3000		Section 1								20 344		8,8A	
her (please specify)			1000	12. 34.				2.6		skitas Gerai				1407					
Do you use tobacco? Current Every Day S. Type of Tobacco? Cigarettes	moker O	Current Some	Day	Smo	ker		N. (leve			F	orm	er S	Smol	ær			Pas	:si
_	Pipe '	() Cigars											•						
Quit Date	74.11.21	Packs per Da	у				Υe	ears											
Smokeless Tobacco Current User	Use? O Never Use	ed C) For	mer	User														
	obacco?																		
Type of Smokeless To Snuff C Are you ready to quit	· ·	O No				•	•	•							•				

· O No

Use per Week: Types?

Depressants

Yes

____ Glasses of wine

Do you use recreational drugs?

Cocaine

___ Drinks containing 0.4 oz of alcohol

Comment:

Methamphetamine

____ Shots of liquor

Stimulants

Heroin

__ Cans of beer

Marijuana

Hallucinoogens