Print in Color or Grayscale Only
Using Adobe Acrobat Reader 8.0 or later

# Review of Systems

Please answer every question

PLEASE PRINT PATIENT'S LAST NAME

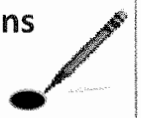
PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH

Month Day Year

## Marking Instructions

Please use a # 2 pencil
Fill in the complete oval as shown...



## Please mark only the symptoms you CURRENTLY are experiencing.

**Mark all that apply ---- if no symptoms, please mark "NONE"**

| | | | |
|---|---|---|---|
| **General** | | | |
| | weight loss ◯ | fever ◯ | |
| fatigue ◯ | weight gain ◯ | persistent infections ◯ | NONE ◯ |
| **Eyes** | | | |
| | visual disturbances ◯ | glasses / contacts ◯ | NONE ◯ |
| **Ear, Nose, and Throat** | | | |
| | hearing loss ◯ | sinus pain ◯ | |
| | seasonal allergies ◯ | oral ulcers ◯ | NONE ◯ |
| **Cardiovascular** | | | |
| | chest pain ◯ | swelling hands / feet ◯ | |
| difficulty breathing on exertions ◯ | palpitations ◯ | shortness of breath ◯ | NONE ◯ |
| **Respiratory** | | | |
| | | chronic cough ◯ | |
| wheezing ◯ | difficulty breathing ◯ | coughing blood ◯ | NONE ◯ |
| **Breast** | | | |
| mass / lump ◯ | breast pain ◯ | nipple discharge ◯ | NONE ◯ |
| **Gastrointestinal** | | | |
| | constipation ◯ | bloody stool ◯ | |
| nausea ◯ | chronic diarrhea ◯ | hemorrhoids ◯ | |
| vomiting ◯ | abdominal pain ◯ | excessive gas ◯ | |
| change in bowel habits ◯ | jaundice ◯ | heartburn ◯ | |
| pain with swallowing ◯ | fecal incontinence ◯ | difficulty swallowing ◯ | NONE ◯ |
| **Female Genitourinary (Women Only)** | | | |
| | | blood in urine ◯ | |
| pelvic pain ◯ | vaginal dryness ◯ | painful urination ◯ | |
| urinary frequency ◯ | vaginal discharge ◯ | painful menstruation ◯ | |
| urinary urgency ◯ | vaginal itch or burning ◯ | menstrual irregularities ◯ | |
| excessive urination at night ◯ | painful intercourse ◯ | urine leakage ◯ | NONE ◯ |
| **Male Genitourinary (Men Only)** | | | |
| urine leakage ◯ | urinary frequency ◯ | testicular mass ◯ | |
| painful urination ◯ | urinary urgency ◯ | testicular pain ◯ | |
| change in urinary stream ◯ | impotence ◯ | penile lesions ◯ | |
| excessive urination at night ◯ | urethral discharge ◯ | blood in urine ◯ | NONE ◯ |
| **Musculoskeletal** | | | |
| joint pain ◯ | muscle pain ◯ | muscle weakness ◯ | NONE ◯ |
| **Skin** | | | |
| dry skin ◯ | rash ◯ | new sore / lesion ◯ | |
| change in wart or mole ◯ | hives ◯ | skin ulcer ◯ | NONE ◯ |
| **Neurologic** | | | |
| fainting ◯ | numbness ◯ | seizures ◯ | |
| decreased memory ◯ | trouble walking ◯ | headaches ◯ | NONE ◯ |
| **Psychiatric** | anxiety ◯ | frequent crying ◯ | |
| change in sleep pattern ◯ | depression ◯ | fearful ◯ | NONE ◯ |
| **Endocrine** | | cold intolerance ◯ | |
| hair changes ◯ | heat intolerance ◯ | hot flashes ◯ | NONE ◯ |
| **Heme/Lymphatic** | | | |
| easy bruising ◯ | excessive bleeding ◯ | gland problems ◯ | NONE ◯ |



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Direction of Feed

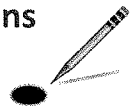
# Personal / Family History

Please answer every question

***STAFF:*** *Handwritten items must be entered* ***MANUALLY.*** *Do not fold this form.*

## Marking Instructions

Please use a #2 pencil.
Fill in the complete oval as shown...



PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH Month Day Year

### TOBACCO USE

What is your smoking status? current (every day) ○ current (some days) ○ previous ○ never ○

At what age did you begin smoking?

If you quit smoking, at what age did you quit?

**EXAMPLE**
If you started smoking at the age of 21, you would fill in the ovals like this:
10 20 30
1 2 3

How many cigarettes do you currently smoke or did you previously smoke per day?

10 20 30 40 50 60 70 80 90
1 2 3 4 5 6 7 8 9

How many cigars or pipes do you smoke per week? 0 ○ <1 ○ 1-2 ○ 3-5 ○ 6-9 ○ 10+ ○

How many cans of smokeless / chewing tobacco do you use per week? 0 ○ <1/2 ○ 1/2 ○ 1 ○ 2 ○ 3+ ○

Are you exposed to passive (second hand) smoke? yes ○ no ○

### ALCOHOL USE

How often do you use alcohol? (Number of times...) never ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7+ ○ (Per...) week ○ month ○ year ○

(If you marked "never", please skip to Drug Use section)

What type(s) of alcohol do you drink? beer ○ wine ○ liquor ○

How many drinks do you have per occasion? 1-2 ○ 3-5 ○ 6-9 ○ 10+ ○

How often do you have more than five drinks per occasion? never ○ occasionally ○ rarely ○ frequently ○

### DRUG USE

none ○ current ○ previous ○ prefer to discuss with physician ○

### HIV HIGH RISK BEHAVIOR?

(HIV Risk Factors: IV drug use, More than one sexual partner, Sex with a prostitute, Unprotected sexual contact, Contact with contaminated injection equipment.)

yes ○ no ○ prefer to discuss with physician ○

### HABITS

Caffeine
-type(s) of caffeine: coffee ○ tea ○ soft drinks ○
-drinks per day: occasionally ○ 0 ○ 1-2 ○ 3-4 ○ 5-6 ○ 7+ ○

Exercise
-type(s) of exercise: bicycling ○ running ○ swimming ○ walking ○ aerobics ○ other ○
-times per week: occasionally ○ 0 ○ 1-2 ○ 3-4 ○ 5-6 ○ 7+ ○

How often do you wear a seatbelt? always ○ almost always ○ occasionally ○ never ○

Sun Exposure: occasionally ○ frequently ○ rarely ○

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Direction of Feed

# Personal / Family History

Please answer every question

***STAFF:** Handwritten items must be entered **MANUALLY**. Do not fold this form.*

## YOUR Medical History

**Please indicate if YOU have a history of the following:**

- ◯ Alcohol Abuse
- ◯ Anemia
- ◯ Anesthetic Complication
- ◯ Anorexia / Eating Disorder
- ◯ Anxiety Disorder
- ◯ Arthritis
- ◯ Asthma
- ◯ Autoimmune Problems
- ◯ Birth Defects
- ◯ Bladder Problems
- ◯ Bleeding Disease
- ◯ Blood Clots
- ◯ Blood Transfusion(s)
- ◯ Breast Cancer
- ◯ Cervical Cancer
- ◯ Colon Cancer
- ◯ Crohn's Disease
- ◯ Depression
- ◯ Diabetes
- ◯ Gallstones
- ◯ Growth / Development Disorder
- ◯ Heart Attack
- ◯ Heart Disease
- ◯ Hepatitis A
- ◯ Hepatitis B
- ◯ Hepatitis C
- ◯ High Blood Pressure
- ◯ High Cholesterol
- ◯ HIV
- ◯ Kidney Disease
- ◯ Liver Cancer
- ◯ Liver Disease
- ◯ Lung Cancer
- ◯ Lung / Respiratory Disease
- ◯ Mental Illness
- ◯ Migraines
- ◯ Osteoporosis
- ◯ Ovarian Cancer
- ◯ Prostate Cancer
- ◯ Rectal Cancer
- ◯ Reflux / GERD
- ◯ Seizures / Convulsions
- ◯ Severe Allergy
- ◯ Sexually Transmitted Disease
- ◯ Skin Cancer
- ◯ Sleep Apnea
- ◯ Stroke / CVA of the Brain
- ◯ Suicide Attempt
- ◯ Thyroid Problems
- ◯ Tuberculosis / Histoplasmosis
- ◯ Ulcer
- ◯ Ulcerative Colitis
- ◯ Other Disease, Cancer, or Significant Medical Illness
- ◯ **NONE of the Above**

## FAMILY Medical History

**Please indicate which family members have had these illnesses:**

- ◯ **FAMILY HISTORY UNKNOWN**
- ◯ **NO SIGNIFICANT FAMILY HISTORY**

| Mother | Father | Sister | Brother | Daughter | Son | |
|---|---|---|---|---|---|---|
| ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | Alcohol Abuse |
| ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | Anemia |
| ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | Anesthetic Complication |
| ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | Arthritis |
| ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | Asthma |
| ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | Bladder Problems |
| ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | Bleeding Disease |
| ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | Breast Cancer |
| ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | Colon Cancer |
| ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | Crohn's Disease |
| ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | Depression |
| ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | Diabetes |
| ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | Heart Disease |
| ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | Hemochromatosis |
| ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | High Blood Pressure |
| ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | High Cholesterol |
| ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | Kidney Disease |
| ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | Liver Disease |
| ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | Lung / Respiratory Disease |
| ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | Migraines |
| ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | Osteoporosis |
| ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | Rectal Cancer |
| ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | Seizures / Convulsions |
| ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | Severe Allergy |
| ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | Stroke / CVA of the Brain |
| ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | Thyroid Problems |
| ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | Ulcerative Colitis |
| ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | Other Cancer |

- ◯ Mother, Grandmother, or Sister developed heart disease before the age of 65
- ◯ Father, Grandfather, or Brother developed heart disease before the age of 55

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# Surgeries

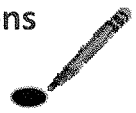
PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH (Month / Day / Year)

## Marking Instructions

Please use a # 2 pencil
Fill in the complete oval as shown...



## Please mark all surgeries you have had.

◯ I have had no Surgeries. (no need to complete questionnaire)

| | | | |
|---|---|---|---|
| ◯ **Anal Fissure Repair** | ◯ **Low Back Disc Surgery** | ◯ **Tonsillectomy** | ◯ **Deviated Nose Septum** |
| ◯ **Appendectomy** | ◯ **Neck Disc Surgery** | ◯ **Ulcer Surgery** | ◯ **Tubal Ligation** |
| ◯ **Hemorrhoidectomy** | ◯ **Sinus Surgery** | ◯ **Vasectomy** | |

| | | | | |
|---|---|---|---|---|
| **Prostate Surgery** | ◯ TURP | ◯ Removal | | |
| **Gallbladder Surgery** | ◯ Open | ◯ Laparoscopic | | |
| **Colon Polyp Removal** | ◯ Open | ◯ Colonoscopy | | |
| **Colon Removal** | ◯ Partial | ◯ Complete | | |
| **Hysterectomy** (due to cancer) | ◯ Partial | ◯ Complete | | |
| **Hysterectomy** (not due to cancer) | ◯ Partial | ◯ Complete | | |
| **Spinal Fusion** | ◯ Neck | ◯ Lower Back | | |
| **Spinal Decompression** | ◯ Neck | ◯ Lower Back | | |
| **Dilation and Curettage (D&C)** | ◯ Single | ◯ Multiple | | |
| **Lung Surgery** | ◯ Left | ◯ Right | ◯ Both | |
| **Kidney Removal** | ◯ Left | ◯ Right | ◯ Both | |
| **Cataract Surgery** | ◯ Left | ◯ Right | ◯ Both | |
| **Breast Cancer Lump Removal** | ◯ Left | ◯ Right | ◯ Both | |
| **Mastectomy** | ◯ Left | ◯ Right | ◯ Both | |
| **Breast Reconstruction** | ◯ Left | ◯ Right | ◯ Both | |
| **Breast Reduction** | ◯ Left | ◯ Right | ◯ Both | |
| **Ovary Removal** | ◯ Left | ◯ Right | ◯ Both | |
| **Carpal Tunnel Surgery** | ◯ Left | ◯ Right | ◯ Both | |
| **Rotator Cuff Repair** | ◯ Left | ◯ Right | ◯ Both | |
| **Arthroscopic Shoulder Surgery** | ◯ Left | ◯ Right | ◯ Both | |
| **Hip Fracture & Surgery** | ◯ Left | ◯ Right | ◯ Both | |
| **Total Hip Replacement** | ◯ Left | ◯ Right | ◯ Both | |
| **Total Knee Replacement** | ◯ Left | ◯ Right | ◯ Both | |
| **Arthroscopic Knee Surgery** | ◯ Left | ◯ Right | ◯ Both | |
| **Foot Surgery** | ◯ Left | ◯ Right | ◯ Both | |
| **Leg Circulation Surgery** | ◯ Left | ◯ Right | ◯ Both | |
| **Mastoidectomy** | ◯ Left | ◯ Right | ◯ Both | |
| **Thyroid Removal** | ◯ Left | ◯ Right | ◯ Total | ◯ Partial |
| **Breast Biopsy** | ◯ Left | ◯ Right | ◯ Both | ◯ Multiple times |
| **Carotid Artery Surgery** | ◯ Left | ◯ Right | ◯ Both | ◯ Multiple times |
| **Open Inguinal Hernia Surgery** | ◯ Left | ◯ Right | ◯ Both | ◯ Multiple times |
| **Laparoscopic Inguinal Hernia Surgery** | ◯ Left | ◯ Right | ◯ Both | ◯ Multiple times |
| **Caesarean Section** | ◯ 1 | ◯ 2 | ◯ 3 or more | |
| **Heart Valve Replacement** | ◯ Mitral | ◯ Aortic | ◯ Tricuspid | ◯ Unknown Valve |
| **Heart Bypass Surgery** | ◯ 1 vessel | ◯ 2 vessels | ◯ 3 vessels | ◯ 4 or more vessels |
| | ◯ Unknown number of vessels | | | |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urology& oncology SPECIALISTS PC

Patient Name _____ Patient DOB _____

Referring Physician _____ Last 4 of SS # _____

**Please Print**

| **ALLERGIES** List all allergies to medications, also include food and latex | Reaction Experienced |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |

**PLEASE CHECK BOX IF YOU HAVE NO KNOWN ALLERGIES** ☐

| **MEDICATIONS** Name of Medication/Vitamins/Herbal Supplement or Diet Pill | Dose and Frequency | Reason for Medication |
|---|---|---|
| | | |
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# AUA BPH Symptom Score Questionnaire

Patient Name _____ Date of birth _____ Date completed:_____

| | Not at All | Less than 1 in 5 Times | Less than Half the Time | About Half the Time | More then Half the Time | Almost Always | Your Score |
|---|---|---|---|---|---|---|---|
| 1. Over the past month, how often have you had a sensation of not emptying your bladder completely after you finished urinating? | 0 | 1 | 2 | 3 | 4 | 5 | |
| 2. Over the past month, how often have you had to urinate again less than two hours after you finished urinating? | 0 | 1 | 2 | 3 | 4 | 5 | |
| 3. Over the past month, how often have you stopped and started again several times when you urinated? | 0 | 1 | 2 | 3 | 4 | 5 | |
| 4. Over the past month, how often have you found it difficult to postpone urination? | 0 | 1 | 2 | 3 | 4 | 5 | |
| 5. Over the past month, how often have you had a weak urinary stream? | 0 | 1 | 2 | 3 | 4 | 5 | |
| 6. Over the past month, have you had to push or strain to begin urination? | 0 | 1 | 2 | 3 | 4 | 5 | |
| | None | 1 Time | 2 Times | 3 Times | 4 Times | 5 or More | |
| 7. Over the past month, how many times did you most typically get up to urinate from the time you went to bed at night until the time you got up in the morning? | 0 | 1 | 2 | 3 | 4 | 5+ | |
| Total Symptom Score | | | | | | | |

Score: 1-7: Mild 8-19: Moderate 20-35: Severe

The possible total runs from 0 to 35 points with higher scores indicating more severe symptoms. Scores less than seven are considered mild and generally do not warrant treatment.

**Disclaimer: This material is provided for information purposes only and is not a substitute for a consultation. You should consult with a urologist regarding your specific symptoms.**

# Medical Records Release Authorization

I hereby authorize _____

to release information from my records to:

**Urology & Oncology Specialists, PC**
101 Memorial Hospital Drive
Suite 100
Mobile, AL 36608-1771
Fax: (251) 380-1582

The purpose or need for this release of information is: _____

The specific information to be disclosed is:

[ ] Physician's chart notes
[ ] History and physical
[ ] Radiological reports
[ ] Laboratory reports
[ ] Operative reports
[ ] Pathology reports
[ ] Medications
[ ] Other _____

Note: Special dates of interest: _____ to _____

I understand that this consent is subject to written revocation by me at any time except in those circumstances in which action has been taken in reliance of it. Without such written express revocation, this consent will expire one year from the day I sign this authorization.

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS Virus), sexually transmitted diseases, psychiatric disorders, or mental health or drug or alcohol use. If I have been tested, diagnosed, or treated for HIV (AIDS Virus), sexually transmitted diseases, psychiatric disorders, or mental health or drug or alcohol use, you are specifically authorized to release all health care information pertaining to such diagnosis, testing or treatment.

Authorization must be signed by the patient. If the patient is a minor or is an incompetent adult, authorization must be signed by their guardian. If there is no guardian appointed by the Court, the authorization must be signed by the nearest relative. If patient is unable to sign this authorization, please state the reason:

_____

Chart #: _____

Patient Name: _____

SSN#: _____ Date of Birth: _____

Address: _____

Phone No.: _____

Signature of patient: X _____ Date: _____

Relationship, if other than patient _____

Witness: X _____ Date: _____

# UROLOGY & ONCOLOGY SPECIALISTS, P.C.

## VERBAL RELEASE OF INFORMATION

**Patient Name:** _____ **DOB:** _____

Urology & Oncology Specialists, P.C. is allowed to give verbal medical information or updates about your condition to your Power of Attorney/Legal Representative as listed in your medical record.

If you wish others, such as relatives or friends, **who ask** about your condition, the right to be verbally informed about your condition when they ask, please list the names of those people on the lines below.

I am authorizing the release of verbal/written medical information regarding my treatment, care, and updates on my condition and also financial information regarding account payments, balance, etc. to the following individuals:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

- I understand that Urology & Oncology Specialists, P.C. will continue to rely on the information on the form when communicating with family members or others involved in my care unless I request changes.
- I understand that I may revoke this authorization at anytime.
- I understand that if I revoke this authorization I must do so in writing and present my written revocation to the privacy officer at Urology & Oncology Specialists, P.C. The revocation will not apply to information that has already been disclosed prior to receipt of written revocation.

**I give permission for personnel from Urology and Oncology Specialists, P.C. to leave a message that may include health or financial information on the answering machine or voice mail system of my phone or of the above phone numbers.**

**YES or NO**

_____ _____

**Patient Signature or Guardian** **Date**

_____ _____

**Witness** **Date**