UROLOGY TREATMENT CENTER

A Division of 21st Century Oncology, LLC

3325 S. Tamiami Trail, Suite 200 • Sarasota, FL 34239

(941) 917-8488 • Fax (941) 917-8475

NAME_____ **DATE**_____

HISTORY

Reason for this visit_____

Duration of above complaint (weeks, months, years)_____

Frequency of urination Daytime_____ Nighttime_____

Strength of Stream Normal_____ Decreased_____ Poor_____

Please Circle YES or NO

Blood in Urine	Yes	No	Leakage of Urine	Yes	No
Urinary Infections	Yes	No	Interruption of Urinary Stream	Yes	No
Kidney or Bladder Stones	Yes	No	Split Stream	Yes	No
Urgent Urination	Yes	No	Burning / Discomfort w/Urination	Yes	No
Dribbling After Voiding	Yes	No	Hesitancy in Initiating Stream	Yes	No

RECENT X-RAYS Yes No If yes, what type of x-rays were performed and where?

_____

CURRENT MEDICATIONS (INCLUDING ASPIRIN) AND DOSE

_____

_____

_____

ALLERGIES

_____

_____

_____

TO BE COMPETED BY PHYSICIAN

HISTORY OF PRESENT ILLNESS

_____

_____

_____

SOCIAL HISTORY

_____

_____

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NAME:_____

PAST MEDICAL HISTORY:

Previous Hospital Admissions and/or Surgery. Please list in chronological order with the approximate dates:

_____

_____

_____

PREVIOUS MEDICAL ILLNESSES- (such as TB, High Blood Pressure, Heart Attack, etc)

_____

_____

FAMILY HISTORY: PLEASE CIRCLE ONE:

			Relationship to You
Diabetes	Yes	No	_____
Heart Disease	Yes	No	_____
Tuberculosis	Yes	No	_____
Kidney Disease	Yes	No	_____
Cancer	Yes	No	_____

Type of Cancer:_____

Other:_____

TRANSFUSION HISTORY:

Have you ever had a blood transfusion Yes____No_____

If yes, When_____

How Many?_____

ALCOHOL USE PER WEEK:_____

EXPOSURE TO: Dye Industry: Yes No Rubber Industry: Yes No Paint Industry: Yes No

Do You Have Now or Have You Had Problems Relating to the Following Systems? Circle Yes or No

HEENT:

Recent vision changes	Yes	No
Hoarseness	Yes	No
Swallowing changes	Yes	No
Hearing Aids	Yes	No

CARDIOVASCULAR/RESPIRATORY:

Heart Palpitations	Yes	No
History of Heart Attack	Yes	No
Shortness of Breath	Yes	No
High Blood Pressure	Yes	No
Chronic Cough	Yes	No
Asthma	Yes	No
Smoking	Yes	No

If yes, how many_____

If stopped, When_____

How long did you smoke_____

HEMATOLOGIC

History of Bleeding	Yes	No
Easy Bruising	Yes	No

ENDOCRINE

Are you a Diabetic	Yes	No

PSYCHOLOGIC

History of Depression	Yes	No

GYNECOLOGIC:

Are you pregnant	Yes	No

Last Menstrual Date_____

Menopause if Yes age_____

Difficulty Having Intercourse	Yes	No

GASTROINTESTINAL

Diarrhea	Yes	No
Constipation	Yes	No
Blood in Stool/Black Stool	Yes	No
Abdominal Pain/Indigestion	Yes	No
Nausea/Vomiting	Yes	No
History of Ulcer	Yes	No

NEUROLOGIC

Headaches	Yes	No
History of Fainting/Seizures	Yes	No
History of Numbness/Weakness	Yes	No

INTEGUMENTARY

History of Jaundice	Yes	No
Skin Rash in Genital Area	Yes	No

MUSCULOSKELETAL

Back Pain	Yes	No

Physician's Signature_____ **Date**_____