UTSouthwestern Medical Center

Urology Outpatient Clinic
Review of Systems

Pt. Name: ______________________
Address: ______________________
____
City State Zip
MRN: ______________________
DOB: ______________________
SSN: XXX-XX-______ SEX: ______
DOS: ______________________

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

	Yes	No		Yes	No		Yes	No
Fever	◯	◯	Chills	◯	◯	Weight Loss	◯	◯
Weight Gain	◯	◯	Malaise/Fatigue	◯	◯	Excessive Sweating	◯	◯
General Weakness	◯	◯						

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

	Yes	No		Yes	No		Yes	No
Rash	◯	◯	Itching	◯	◯	New/Changing Lesions	◯	◯
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	No		Yes	No		Yes	No
Headaches	◯	◯	Difficulty Hearing	◯	◯	Ringing in the Ears	◯	◯
Ear Discharge	◯	◯	Ear Pain	◯	◯	Nosebleeds	◯	◯
Nasal Stuffiness	◯	◯	Snoring	◯	◯	Difficulty Swallowing	◯	◯
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	◯	◯	Double Vision	◯	◯	Pain Looking at Bright Lights	◯	◯
Eye Pain	◯	◯	Eye Discharge	◯	◯	Eye Redness	◯	◯

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

	Yes	No		Yes	No		Yes	No
Chest Pain	◯	◯	Palpitations	◯	◯	Difficulty Breathing When Lying Flat	◯	◯
Pain in Legs when Walking	◯	◯	Leg or Ankle Swelling	◯	◯			

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

	Yes	No		Yes	No		Yes	No
Cough	◯	◯	Coughing Blood	◯	◯	Sputum Production	◯	◯
Shortness of Breath	◯	◯	Wheezing	◯	◯			

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Gastrointestinal: In general, on a regular basis, are you experiencing any of the following stomach and intestinal symptoms?

	Yes	No		Yes	No		Yes	No
Heartburn			Change in Appetite			Nausea		
Vomiting			Abdominal Pain			Diarrhea		
Constipation			Blood in the Stool			Black Stool		
Incontinence of Stool								

Genitourinary: In general, on a regular basis, are you experiencing any of the following sexual, kidney, or bladder symptoms?

	Yes	No		Yes	No		Yes	No
Burning when Urinating			Urgency to Urinate			Blood in Urine		
Pain when Urinating			Vaginal Discharge			Penile Discharge		
Frequency in Urination			Experience Incomplete Emptying when Urinating			Wake from Sleep to Urinate		
Incontinence of Urine			Sexual Problems					

Musculoskeletal: In general, on a regular basis, are you experiencing any of the following muscle and bone symptoms?

	Yes	No		Yes	No		Yes	No
Muscle Pain			Neck Pain			Back Pain		
Joint Pain			Falls					

Environmental/Allergy: In general, on a regular basis, are you experiencing any of the following symptoms?

	Yes	No		Yes	No		Yes	No
Environmental Allergies			Seasonal Allergies			Frequent Thirst		
Heat Intolerance			Cold Intolerance			Abnormal Bruising/Bleeding		

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

	Yes	No		Yes	No		Yes	No
Dizziness			Tingling			Tremor		
Numbness			Speech Change			Loss of Strength		
Seizures			Loss of Consciousness					

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

	Yes	No		Yes	No		Yes	No
Depression			Substance Abuse			Hallucinations		
Nervous/Anxious			Insomnia			Memory Loss		

UTSouthwestern
Medical Center

Health History Questionnaire

Name
Address
City State Zip
MRN
DOB
Sex Race
DOS

Allergies:

Medication or Substance	Reaction

Current Medications and Over-the-Counter Medicines:

Name	Dose	Frequency

Medical History:

	Yes	No	Date First Noted (approximately)	Comments
Allergies	○	○		
Anemia	○	○		
Angina	○	○		
Anxiety Disorder	○	○		
Arthritis	○	○		
Asthma	○	○		
Atrial Fibrillation	○	○		
Bowel Disease	○	○		
Breast Cancer	○	○		
Colorectal Cancer	○	○		
Congestive Heart Failure	○	○		
Chronic Obstructive Pulmonary Disease (COPD)	○	○		
Coronary Artery Disease	○	○		

UTSouthwestern
Medical Center

Health History Questionnaire

Medical History (continued):

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

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Health History Questionnaire

Surgical History:

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

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Health History Questionnaire

Address

DOS.

Family History:

Relationship	Name	Status (Alive or Deceased)	History of Alcohol or Drug Problems	Allergies	Problems with Anesthesia	Arthritis	Blood Diseases	Cancer	Diabetes	Genetic	Gastrointestinal Problems	Genitourinary (GU)	Heart	Hypertension	Lipid Problems	Neurological	Psychiatric Problems	Stroke	Thyroid	Other (please specify)
Mother																				
Father																				
Sister																				
Brother																				
Maternal Grandmother																				
Maternal Grandfather																				
Paternal Grandmother																				
Paternal Grandfather																				
Daughter																				
Son																				
Other (please specify)																				

Substance History:

Do you use tobacco?

◯ Current Every Day Smoker ◯ Current Some Day Smoker ◯ Never ◯ Former Smoker ◯ Passive

Type of Tobacco?

◯ Cigarettes ◯ Pipe ◯ Cigars

Quit Date ____________ Packs per Day ________ Years ________

Smokeless Tobacco Use?

◯ Current User ◯ Never Used ◯ Former User

Type of Smokeless Tobacco?

◯ Snuff ◯ Chew

Are you ready to quit? ◯ Yes ◯ No

Do you use alcohol?

◯ Yes ◯ No Comment: ______________________________

Drinks per week:

______ Glasses of wine ______ Cans of beer ______ Shots of liquor

______ Drinks containing 0.4 oz of alcohol

Do you use recreational drugs?

◯ Yes ◯ No Comment: ______________________________

Use per Week: ______

Types? ◯ Cocaine ◯ Marijuana ◯ Methamphetamine ◯ Stimulants ◯ Heroin

◯ Depressants ◯ Hallucinoogens