UROMEDIX
PROVIDING UROLOGIC CARE & SURGERY
A Division of 21st Century Oncology, LLC

SOCIAL HISTORY

Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Divorced ❑ Separated

Do you now or have you ever smoked? ❑ Yes ❑ No If Yes, when did you quit? Date: _____

How much Beer, Wine or Alcohol do you drink per week _____ Recreational drugs ❑ Yes ❑ No

What kind of work do you do now, or did you do? _____

Exposure to chemicals, toxins, fumes, radiation or excessive heat (regular use of Hot Tub, Jacuzzi, Sauna, or Whirlpool)? _____

How much Coffee, Tea, Iced Tea, or Caffeinated Beverages? _____ How much water do you drink? _____

Do you eat a lot of spicy, pickled or acidic foods? ❑ Yes ❑ No

Males

Date of last PSA _____

Last Prostate exam _____

Enlarged prostate ❑ Yes ❑ No

Testicular pain/enlargement ❑ Yes ❑ No

Females

Age at first period, _____ Age of last period _____

Number of Pregnancies _____ Age at 1st pregnancy _____ Number of live births _____

Date of last mamogram _____, Last PAP _____

Ever taken Birth Control/Estrogen ❑ Yes ❑ No

Review of Systems

Do you now or have you had any problems related to the following systems? - Circle **Y**es or **N**o

Constitutional Symptoms

Fever	Y	N
Chills	Y	N
Headache	Y	N
Change in appetite, weight, energy	Y	N

Other _____

Neurological

Tremors	Y	N
Dizzy Spells	Y	N
Numbness/Tingling	Y	N
Seizures	Y	N

Other _____

Endocrine

Excessive thirst	Y	N
Too hot/cold	Y	N
Tired/sluggish	Y	N

Other _____

Gastrointestinal

Abdominal pain	Y	N
Nausea/vomiting	Y	N
Indigestion/heartburn	Y	N
Change stool size/shape/color	Y	N
Pain with swallowing	Y	N

Other _____

Cardiovascular

Chest pain	Y	N
Rapid heart rate	Y	N
High blood pressure	Y	N

Other _____

Integumentary

Skin rash	Y	N
Boils	Y	N
Persistent itch	Y	N

Other _____

Musculoskeletal

Neck pain	Y	N
Joint swelling/pain	Y	N
Back pain	Y	N
Bone pain	Y	N

Other _____

Respiratory

Wheezing	Y	N
Frequent cough	Y	N
Shortness of breath	Y	N

Other _____

Hemtologic/Lymphatic

Swollen glands	Y	N
Blood clotting problem	Y	N
Prior blood transfusions	Y	N

Other _____

Psychologic

Are you generally satisfied with your life?	Y	N
Do you feel severely depressed?	Y	N
Have you considered suicide?	Y	N

Other _____

Patient Signature _____ Date _____

Physician's Signature _____ Date _____