

Advanced Urology

6 ROBOTIC SURGERY

A Division of 21st Century Oncology, LLC

NAME PLATE

NAME _____ Age _____ M _____ F _____ DATE _____
 ADDRESS _____ PHONE _____

HISTORY OF PAST ILLNESS: Have you had

Childhood:

- Measles Mumps Chicken Pox
 Congenital Abnormalities Rheumatic fever or heart disease

Adult:

- Asthma High Blood Pressure Cancer (Site _____)
 Diabetes Ulcer or Gastritis Thyroid Problems
 Tuberculosis Kidney Problem Liver Problems
 Blood Problem Venereal Disease Heart Failure
 Heart Attack Abnormal Heart Rhythm

Have you had any serious illness? No Yes
 Have you ever had a transfusion? No Yes
 Have you ever been hospitalized or
 been under medical care for very long? No Yes

If yes, for what reason? _____

Most recent immunizations:

Hepatitis B _____ (date) Flu Vaccine _____ (date)
 Pneumovax _____ (date) Tetanus _____ (date)

OPERATIONS:

Have you ever had any surgery?
 List: Appendectomy Hysterectomy (If so, reason _____)
 Ovaries removed Joint replacement
 Gallbladder Bypass (if so, what _____)

Other _____

ALLERGIES: _____

MEDICATIONS: _____

INJURIES:

Have you ever been seriously injured in a motor vehicle accident? No Yes
 Have you had any head concussions or injuries? No Yes
 Have you ever been knocked unconscious? No Yes

SOCIAL HISTORY:

Circle One: Single Married Separated
 Divorced Widowed Significant Other

With whom do you live? _____

Recreational drug usage? No Yes
 Do you have any problems with sexual function? No Yes

Foreign travel within last year _____
 Coffee _____ Tea _____ Cola's _____ (per day)
 Alcoholic beverages: Never _____ <1 Per Week _____
 1-5 Per week _____ Other _____
 Tobacco: Never smoked Quit _____ years ago

Years smoked _____ Packs per day _____

SOCIAL HISTORY (continued):

Are you employed? Full time _____ Part time _____
 What is your job? _____

Are you exposed to fumes, dusts or solvents? _____

How much time have you lost from work because of your health during the past:

Six months _____ One year _____ Five years _____

Education (Years):

Grade school _____ College _____ Post graduate _____

Do you wear seatbelts? Always Sometimes Never

FAMILY HISTORY	AGE	HEALTH	If Deceased, Age at Death	Cause of Death
Father				
Mother				
Brother/Sister				
Husband/Wife				
Son/Daughter				

Has either parent, sister, brother, child or grandparent ever had?

Stroke	No	Yes	Heart Trouble	No	Yes
Tuberculosis	No	Yes	High Blood Pressure	No	Yes
Diabetes	No	Yes			

Has any blood relative ever had?

Cancer	No	Yes	Bleeding Tendency	No	Yes
Type:			Gout or other crippling arthritis		
Suicide:	No	Yes		No	Yes
Mental Illness	No	Yes	Hereditary Defects	No	Yes

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CIRCLE NO OR YES FOR THOSE THAT APPLY

SYSTEMIC REVIEW: Do you have any of the following?

General: Maximum weight _____ Minimum Weight _____
Recent weight change?..... No Yes
Have you been in good general health most of your life?... No Yes
Have you recently had?
 Weakness Fever Chills Night Sweats
 Fainting Problems Sleeping

Skin:

Skin Disease..... No Yes
Jaundice..... No Yes
Hives, eczema or rash..... No Yes

Head-Eyes-Ears-Nose-Throat (cont'd):

Dry eyes or mouth..... No Yes
Bleeding Gums – Frequent or Constant..... No Yes
Blurred Vision..... No Yes
Date of Last Eye Exam _____
Sniffling or runny nose..... No Yes
Nosebleeds – Frequent..... No Yes
Chronic sinus trouble..... No Yes
Ear disease..... No Yes
Impaired hearing..... No Yes
Dizziness or sensation of room spinning..... No Yes
Frequent or severe headaches..... No Yes

Respiratory:

Asthma or wheezing..... No Yes
Difficulty breathing..... No Yes
Any trouble with lungs..... No Yes
Pleurisy or pneumonia..... No Yes
Cough up blood (ever)..... No Yes

Cardiovascular:

Chest pain, pressure, or tightness..... No Yes
Shortness of breath with walking or lying down..... No Yes
Difficulty walking two blocks..... No Yes
Palpitations..... No Yes
Swelling of hands, feet or ankles..... No Yes
Awakening in the nights smothering..... No Yes
Heart murmur..... No Yes

Gastrointestinal:

Vomiting blood or food..... No Yes
Gallbladder disease..... No Yes
Change in appetite..... No Yes
Hepatitis/Jaundice..... No Yes
Painful bowel movements..... No Yes
Bleeding with bowel movements..... No Yes
Black stools..... No Yes
Hemorrhoids or piles..... No Yes
Recent change in bowel habits..... No Yes
Frequent diarrhea..... No Yes
Heartburn or indigestion..... No Yes
Cramping or pain in the abdomen..... No Yes
Food sticks in the throat..... No Yes

Endocrine:

Hormone therapy..... No Yes
Any change in hat or glove size..... No Yes
Any change in hair growth..... No Yes
Have you become colder than before –
or skin become dryer..... No Yes

Neck:

Stiffness..... No Yes
Enlarged glands..... No Yes

Genitourinary:

Loss of urine..... No Yes
Blood in urine..... No Yes
Frequent urination..... No Yes
Burning or painful..... No Yes
Night time urinating..... No Yes
Kidney trouble..... No Yes
Problem stopping/starting flow of urine..... No Yes
Testicular mass..... No Yes
Testicular pain..... No Yes
Prostate problem..... No Yes
Sexual Dysfunction..... No Yes
STD/ AIDS Risk..... No Yes

Gynecological:

First day of last period _____
Age periods started _____
How long do periods last _____ Days
Frequency of periods every _____ Days
Pain with periods..... No Yes
Number of pregnancies _____
Number of miscarriages _____
Date of last cancer smear and results _____
Breast lump..... No Yes
Abnormal vaginal discharge..... No Yes
Breast discharge..... No Yes
Pain with intercourse..... No Yes
Skin change of breast..... No Yes
Nipple retraction..... No Yes

Locomotor-Musculoskeletal:

Stiffness or pain in joints (check all that apply)
 Finger Hands Wrist Elbows Shoulder Neck Back
 Hip Knee Toes Foot Temporomandibular Joint
Weakness of muscles or joints..... No Yes
Any difficulty in walking..... No Yes
Any pain in calves or buttocks on walking
relieved by rest..... No Yes

Neuro-Psychiatric:

Transient blindness Tremor Numbness in fingers Weakness
Have you ever had counseling for your mental health?..... No Yes
Have you ever been advised to see a psychiatrist?..... No Yes
Do you ever have, or have had, fainting spells?..... No Yes
Convulsions..... No Yes
Paralysis..... No Yes
Problem with coordination..... No Yes
Domestic violence..... No Yes
Depression Symptoms (difficulty sleeping, loss of appetite
loss of interest in activities, feelings of hopelessness)..... No Yes

Hematologic:

Are you slow to heal after cuts?..... No Yes
Anemia..... No Yes
Phlebitis or blood clots in veins..... No Yes
Have you had difficulty with bleeding excessively
after tooth extraction or surgery?..... No Yes
Have you had abnormal bruising or bleeding?..... No Yes

Source of information, if other than patient: _____

Signature of person acquiring this information: _____

Provider

Date

Signature of Patient

V06/04

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Signature of person acquiring this information: _____

Provider

Date

Signature of Patient

V06/04