

Patient Name: \_\_\_\_\_  
DOB: \_\_\_\_\_  
MRN: \_\_\_\_\_

**FOR OFFICE USE ONLY**

Dear Patient,

Welcome to Florida Cancer Specialists & Research Institute (FCS)! Our urology team is committed to providing you with compassionate, personalized care throughout your treatment journey. Throughout your time with us, you will meet a dedicated team of medical assistants, nurses, advanced practice providers (APPs), and urologists. Each is committed to addressing your concerns and providing the highest quality of care to support you on your journey.

APPs are an integral part of our FCS care team. They include advanced practice registered nurses (APRNs) or physician assistants (PAs) who have earned advanced degrees and have specialized training in urology. In addition to providing excellent care, our APPs play a key role in leading healthcare efforts and improving clinical outcomes. They work closely with your physician, who oversees all aspects of your care plan, to ensure it's personalized to your unique needs.

Our experienced urology care team provides comprehensive services, including convenient in-office procedures and advanced outpatient surgeries. Individually and collectively, the members of your care team, including our APPs, are centered on you and committed to making sure you achieve the best possible outcome.

Feel free to ask questions and let us know how we can help you. Thank you for entrusting your care to us.

Sincerely,

Your Florida Cancer Specialists & Research Institute Urology Team  
FLCancer.com

Patient Name: \_\_\_\_\_  
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**FOR OFFICE USE ONLY**

|                                                                                                                                                                                                                                                                                                                                     |         |                                                                                                                                                                                                                                                                           |         |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|
| First Name:                                                                                                                                                                                                                                                                                                                         | Middle: | Last:                                                                                                                                                                                                                                                                     | Suffix: |
| Preferred / Nick Name:                                                                                                                                                                                                                                                                                                              |         | Date of Birth:                                                                                                                                                                                                                                                            |         |
| Primary Address:                                                                                                                                                                                                                                                                                                                    |         | SSN:                                                                                                                                                                                                                                                                      |         |
| City, State, Zip:                                                                                                                                                                                                                                                                                                                   |         | Gender at birth: <input type="checkbox"/> Male <input type="checkbox"/> Female                                                                                                                                                                                            |         |
| Secondary Address:                                                                                                                                                                                                                                                                                                                  |         | Gender Identity (Select one)<br><input type="checkbox"/> Male <input type="checkbox"/> Other _____<br><input type="checkbox"/> Female <input type="checkbox"/> Prefer not to say                                                                                          |         |
| City, State, Zip:                                                                                                                                                                                                                                                                                                                   |         | Preferred Pharmacy: _____                                                                                                                                                                                                                                                 |         |
| From: _____ To: _____                                                                                                                                                                                                                                                                                                               |         | Phone Number: _____                                                                                                                                                                                                                                                       |         |
| Preferred Language: _____                                                                                                                                                                                                                                                                                                           |         | Pharmacy Address: _____                                                                                                                                                                                                                                                   |         |
| Ethnicity:<br><input type="checkbox"/> Hispanic or Latino<br><input type="checkbox"/> Not Hispanic or Latino                                                                                                                                                                                                                        |         | Phone Numbers                                                                                                                                                                                                                                                             |         |
| Race (Select all that apply):<br><input type="checkbox"/> White<br><input type="checkbox"/> Black or African American<br><input type="checkbox"/> Asian<br><input type="checkbox"/> American Indian or Alaska Native<br><input type="checkbox"/> Native Hawaiian or Other Pacific Islander<br><input type="checkbox"/> Other: _____ |         | Home: _____<br>Mobile: _____<br>Other: _____                                                                                                                                                                                                                              |         |
| Have you served or currently are serving in the US Military?<br><input type="checkbox"/> Veteran<br><input type="checkbox"/> Active Duty                                                                                                                                                                                            |         | Preferred Contact: <input type="checkbox"/> Home <input type="checkbox"/> Cell<br>May we leave a voicemail? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>If yes: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Both |         |
| Primary Care Physician: _____<br>Phone Number: _____<br>Do you see your PCP at least yearly? <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                               |         | May we text you? <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                 |         |
| Referring Provider (if different from PCP)<br>Name: _____<br>Phone Number: _____                                                                                                                                                                                                                                                    |         | Emergency Contact: _____<br>Phone Number: _____<br>Relationship: _____                                                                                                                                                                                                    |         |
|                                                                                                                                                                                                                                                                                                                                     |         | Email: _____<br><br>May we email you? <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                            |         |
|                                                                                                                                                                                                                                                                                                                                     |         | Would you like access to the online patient portal?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <u>If yes</u> , provide email address above.                                                                                                              |         |

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**INSURANCE INFORMATION**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Primary Insurance Carrier: \_\_\_\_\_

Name of primary policy holder: \_\_\_\_\_ Policy holder's DOB: \_\_\_\_\_

Policy number/group ID: \_\_\_\_\_

Policy holder's employer: \_\_\_\_\_

Does plan have prescription coverage? ☐ Yes ☐ No

Secondary Insurance Carrier: \_\_\_\_\_

Name of secondary policy holder: \_\_\_\_\_ Policy holder's DOB: \_\_\_\_\_

Policy number/group ID: \_\_\_\_\_

Policy holder's employer: \_\_\_\_\_ Policy holder's SSN: \_\_\_\_\_

Does plan have prescription coverage? ☐ Yes ☐ No

Pharmacy Insurance Carrier: \_\_\_\_\_

Name of pharmacy policy holder: \_\_\_\_\_ RX policy number/RX BIN number: \_\_\_\_\_

I certify that the information provided is accurate. I will notify Florida Cancer Specialists & Research Institute (FCS) of any changes as soon as they become available. I understand that it is my responsibility to update FCS of any changes to my insurance plan, or I may be held liable for the full balance of my treatment.

Patient Name (Print) \_\_\_\_\_ Date of Birth \_\_\_\_\_

Patient or Guarantor (Signature) \_\_\_\_\_ Date \_\_\_\_\_

**MEDIGAP**

*Only applicable for patients with secondary insurance to Medicare*

I request that payment of authorized Medigap benefits be made on my behalf to Florida Cancer Specialists & Research Institute or Rx To Go for any services furnished by \_\_\_\_\_. I authorize any holder of medical information about me to release to \_\_\_\_\_ any information concerning this Medicare claim because my signing this authorization will cause Medicare payment information to cross over automatically.

Patient Name (Print) \_\_\_\_\_ Date of birth \_\_\_\_\_

Patient or Guarantor (Signature) \_\_\_\_\_ Date \_\_\_\_\_

**GENERAL & FINANCIAL CONSENT**

Dear Valued Patient,

Thank you for choosing Florida Cancer Specialists & Research Institute (FCS) as your healthcare provider. Our physicians are committed to providing you with the highest quality care.

Prior to receiving treatment, please read and acknowledge FCS' patient general and financial policies:

- You consent to the rendering of medical care in compliance with healthcare surrogacy laws, which may include diagnostic procedures, next-generation sequencing testing and such medical treatment as your physician(s) or other FCS medical staff consider to be necessary. You may be offered medical services via telemedicine systems that involve the delivery of health care by electronic communication with a provider who is at a different physical location. You consent to initiating and/or receiving technology-based communications with FCS and my providers, including consulting services from a specialist performed virtually. You understand that my medical care and treatment may be provided by physicians, including fellows and residents, medical and allied health students, physician assistants, nurses and other health care providers. You have read and understand this General Consent for Treatment and understand that no guarantee or assurance has been made as to the results that may be obtained.
- You agree to provide FCS with current and accurate insurance, health care benefits program and/or other payer information, and to immediately notify FCS if your coverage changes.
  - You understand that FCS patient financial policies are available online at [FLCancer.com](http://FLCancer.com). You agree that these policies apply to you and may change from time to time without notice.
  - You acknowledge that FCS will bill your insurance plan or program for services provided by FCS and you agree you are assigning your right to receive payment or benefits from such insurer or program to FCS and you are authorizing payment to be made directly to FCS.
- You agree you are responsible for payment to FCS of all co-pays, deductibles and co-insurance applicable under your insurance policy, plan or program. You understand that payment of such amounts is due at the time of service.
- Depending on your insurer, plan or program, some services may not be covered. If your insurance does not authorize or cover a service or treatment and you nevertheless decide to receive such service or treatment, you agree that you are responsible for payment. This applies to all payers in accordance with all applicable law and regulation and payer requirements (including any "advance beneficiary notice" (ABN) which may be applicable under Medicare).
- You authorize FCS and its agents to review your insurance, financial, and demographic information for the purposes of identifying potential financial assistance programs for which you may qualify. This review may include the use of 3<sup>rd</sup> party services to help determine eligibility for financial support.
- To facilitate payment of claims, to perform internal operations and to coordinate your care with other healthcare providers, FCS will use your personal health information internally and will share such information with your insurance policy and certain business associates of FCS in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other applicable federal and state law and regulation.

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**FOR OFFICE USE ONLY**

- FCS owns and operates Rx To Go, a specialty pharmacy that provides certain pharmaceuticals that may be prescribed by your FCS physician and may be covered under your medical or pharmacy benefits plan or program (such as Medicare Part B or Part D). You are not obligated to use Rx To Go and may have your prescriptions filled wherever you choose. However, if you select Rx To Go to fill FCS-issued prescriptions, then this policy and all other FCS patient financial responsibility policies will also apply to the items and services provided to you by Rx To Go.
- You acknowledge that laboratory and/or radiology services may be necessary as part of your care and treatment which may be performed by FCS clinicians at FCS' own facilities. In some cases, services may be provided by outside facilities, in which case, you understand that you may receive a separate bill directly from the outside provider.
- If you make a payment to FCS that results in a surplus on your account (i.e., a credit balance), FCS may hold that amount as a deposit against charges that are subject to ongoing claims processing or charges for scheduled future services, and FCS may apply the surplus against such pending or future scheduled charges. If a surplus still remains after applying all credits, or if at the conclusion of FCS' care a credit balance remains which is not subject to return to your insurer or other payer, FCS will refund the credit balance to you. However, you agree that any refund under \$10.00 will be made only if you make a written request and, in any event, any credit balance under \$10.00 will be forfeited if a refund request is not received within five (5) years after the conclusion of your care.

☐ I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE PATIENT FINANCIAL POLICIES.

*A copy is available to the patient upon request.*

\_\_\_\_\_  
Patient Name (Print)

\_\_\_\_\_  
Date of birth

\_\_\_\_\_  
Patient or Guarantor (Signature)

\_\_\_\_\_  
Date

For office use:

\_\_\_\_\_  
Name (Print)

\_\_\_\_\_  
FCS Employee (Signature)

Patient Name: \_\_\_\_\_  
DOB: \_\_\_\_\_  
MRN: \_\_\_\_\_

**FOR OFFICE USE ONLY**

**GENERAL CONSENT FORM**

SMS Communication Consent

☐ I consent to receive text messages from Florida Cancer Specialists & Research Institute (FCS), Rx To Go, LLC, and any authorized texting service vendor for appointment reminders, billing notices, and other health-related updates. I understand message/data rates may apply and I may opt out at any time by replying "STOP."

☐ I do not consent to receive text messages.

Photo Authorization for Medical Record

☐ I consent to FCS photographing me (digital/photo/video) for inclusion in my electronic medical record (EMR) for identification and documentation purposes.

☐ I do not consent to be photographed for medical record purposes.

Consent Disclosure of Medical Information

☐ I authorize FCS to discuss my medical information with the following individual(s):

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

☐ I request that all my Protected Health Information be disclosed ONLY to me and to no other family members or friends.

Medical Scribe Consent

☐ I give permission for FCS to use a professional medical scribe, who may be virtual, to assist my physician during documentation. I understand this service is provided at no cost and all shared information will remain confidential.

☐ I do not give permission for FCS to use a professional medical scribe.

*Florida Cancer Specialists & Research Institute (FCS) is using an AI Scribe tool to improve patient care by helping providers focus more on you during visits. The AI Scribe listens to your conversation with your provider and creates a clinical note, which your provider reviews and approves before it's added to your medical record. Your privacy is protected through strict adherence to federal and state privacy laws and regulations, with added security measures like encryption and multifactor authentication. Participation is voluntary, and you may withdraw consent at any time.*

Patient Medication Reconciliation

I consent to FCS and its healthcare providers to collect, document, and reconcile my current medications as part of my medical care. This includes but is not limited to, prescription drugs, over-the-counter medications, vitamins, supplements, and herbal remedies and recording the name, dosage, frequency, and route of administration for each medication. This process is essential for ensuring safe and effective treatment and is required under the Merit-based Incentive Payment System (MIPS) guidelines. I may revoke this consent in writing at any time, except to the extent that action has already been taken based on this consent.

☐ Yes

☐ No

Patient (Print Name) \_\_\_\_\_

Date of birth \_\_\_\_\_

Patient (Signature) \_\_\_\_\_

Date \_\_\_\_\_

Patient Name: \_\_\_\_\_  
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**FOR OFFICE USE ONLY**

**ACP – Advance Care Planning Documents (If yes, please provide a copy)**

|                                   |                                                          |  |
|-----------------------------------|----------------------------------------------------------|--|
| Do you have an advance directive? | <input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| Do you have a living will?        | <input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| Do you have a DNR?                | <input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| Do you have a healthcare proxy?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |  |

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

By signing this form, you acknowledge that you have received or have been informed that you have the right to receive a copy of the Florida Cancer Specialists & Research Institute (FCS) Notice of Privacy Practices.

This notice is available in hard copy by verbally requesting a copy at the front desk of any FCS facility or by submitting a request in writing to the corporate office at Florida Cancer Specialists & Research Institute, 2890 Center Pointe Drive, Fort Myers, FL 33916.

You may also obtain a copy of the Notice of Privacy Practices by visiting the FCS website at [FLCancer.com](http://FLCancer.com), select the Patient Guide tab, select New Patient Forms and click on Notice of Privacy Policies.

☐ Accepted ☐ Declined

Patient Name (Print) \_\_\_\_\_ Date of Birth \_\_\_\_\_

Patient or Guarantor (Signature) \_\_\_\_\_ Date \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

**REQUEST FOR RELEASE OF RECORDS**

I authorize Florida Cancer Specialists & Research Institute (FCS) to request a copy of my complete medical record from the provider listed below:

Name of Provider/Facility: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone/Fax: \_\_\_\_\_

I understand that by signing this authorization, I permit FCS to receive my medical, psychiatric, HIV, drug/alcohol, and other sensitive health records, unless otherwise restricted by law. I also understand this authorization is valid until revoked in writing.

Patient Name (Print): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Patient or Guarantor Signature: \_\_\_\_\_ Relationship: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_  
DOB: \_\_\_\_\_  
MRN: \_\_\_\_\_

**FOR OFFICE USE ONLY**

**HEALTH HISTORY**

**ALLERGIES**

| Drug name:                           | Reaction you have: |
|--------------------------------------|--------------------|
|                                      |                    |
|                                      |                    |
|                                      |                    |
|                                      |                    |
|                                      |                    |
|                                      |                    |
| Other Allergens:                     |                    |
| <input type="checkbox"/> CT Dye      |                    |
| <input type="checkbox"/> Iodine      |                    |
| <input type="checkbox"/> Latex       |                    |
| <input type="checkbox"/> Other _____ |                    |

**MEDICATIONS**

Please list all medications you are currently taking, include dosage and frequency. If you have a printed list, you may provide a copy to the office instead.

| Name of Medication: | Strength: | Frequency Taken: |
|---------------------|-----------|------------------|
|                     |           |                  |
|                     |           |                  |
|                     |           |                  |
|                     |           |                  |
|                     |           |                  |
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|                     |           |                  |



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**PAST MEDICAL HISTORY**

Have you ever been told by a doctor/health care professional that you had cancer? ☐ Yes ☐ No

If yes, type of cancer: \_\_\_\_\_ date diagnosed: \_\_\_\_\_

Treating physician and type of treatment: \_\_\_\_\_

Do you have religious restrictions that prevent you from accepting blood transfusions? ☐ Yes ☐ No

Blood Transfusions: \_\_\_\_\_

|                                                         |                                                   |                                                      |
|---------------------------------------------------------|---------------------------------------------------|------------------------------------------------------|
| <input type="checkbox"/> None                           | <input type="checkbox"/> Gallstones               | <input type="checkbox"/> Osteoarthritis              |
| <input type="checkbox"/> Anemia                         | <input type="checkbox"/> GERD/heartburn           | <input type="checkbox"/> Osteoporosis                |
| <input type="checkbox"/> Anxiety disorder               | <input type="checkbox"/> Glaucoma/cataracts       | <input type="checkbox"/> Pancreatitis                |
| <input type="checkbox"/> Asthma                         | <input type="checkbox"/> Hearing loss             | <input type="checkbox"/> Paralysis                   |
| <input type="checkbox"/> Atrial fibrillation            | <input type="checkbox"/> Heart murmur             | <input type="checkbox"/> Parkinson's disease         |
| <input type="checkbox"/> Bleeding disorder              | <input type="checkbox"/> Heart attack-MI          | <input type="checkbox"/> Peripheral vascular disease |
| <input type="checkbox"/> Blood clots                    | <input type="checkbox"/> Heart disease            | <input type="checkbox"/> Pneumonia/bronchitis        |
| <input type="checkbox"/> Blood disorder                 | <input type="checkbox"/> Heartburn/reflux         | <input type="checkbox"/> Problems with anesthesia    |
| <input type="checkbox"/> Cancer                         | <input type="checkbox"/> Hepatitis A/B/C/HIV      | <input type="checkbox"/> Raynaud's syndrome          |
| <input type="checkbox"/> Chronic back pain              | <input type="checkbox"/> Hiatal hernia            | <input type="checkbox"/> Rheumatic fever             |
| <input type="checkbox"/> Chronic lung (COPD)            | <input type="checkbox"/> High blood pressure      | <input type="checkbox"/> Rheumatoid arthritis        |
| <input type="checkbox"/> Cirrhosis of liver             | <input type="checkbox"/> High cholesterol         | <input type="checkbox"/> Seizures                    |
| <input type="checkbox"/> Colon polyps                   | <input type="checkbox"/> Irregular heartbeat      | <input type="checkbox"/> Shingles                    |
| <input type="checkbox"/> Congestive heart failure       | <input type="checkbox"/> Irritable bowel syndrome | <input type="checkbox"/> Sleep apnea                 |
| <input type="checkbox"/> Crohn's disease                | <input type="checkbox"/> Kidney disease/failure   | <input type="checkbox"/> Stomach ulcers              |
| <input type="checkbox"/> Diabetes                       | <input type="checkbox"/> Kidney stone             | <input type="checkbox"/> Stroke                      |
| <input type="checkbox"/> Diverticulitis                 | <input type="checkbox"/> Leukemia                 | <input type="checkbox"/> TB (Tuberculosis)           |
| <input type="checkbox"/> Drug use                       | <input type="checkbox"/> Lupus-autoimmune         | <input type="checkbox"/> Thyroid disease             |
| <input type="checkbox"/> Enlarged prostate              | <input type="checkbox"/> Lymphoma                 | <input type="checkbox"/> Ulcerative colitis          |
| <input type="checkbox"/> Fracture                       | <input type="checkbox"/> Major depression         | <input type="checkbox"/> Other: _____                |
| <input type="checkbox"/> Freq. urinary tract infections | <input type="checkbox"/> Migraines                | <input type="checkbox"/> Other: _____                |
| <input type="checkbox"/> Frequent infections            | <input type="checkbox"/> Neuropathy               | <input type="checkbox"/> Other: _____                |

**PAST SURGERIES**

When

Where

|  |  |   |
|--|--|---|
|  |  | : |
|  |  |   |
|  |  |   |
|  |  |   |

**RECENT HOSPITAL ADMISSIONS**

When

Where

|  |  |   |
|--|--|---|
|  |  | : |
|  |  |   |

**WOMEN'S HEALTH HISTORY** (if not applicable, skip and continue to the next page)

|                                         |                                                                                                |
|-----------------------------------------|------------------------------------------------------------------------------------------------|
| Age menstruation began:                 | Age of menopause (if applicable):                                                              |
| Age at first pregnancy (if applicable): | Were you ever on hormone replacement? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Last menstrual period:                  | If yes, when did you start/stop?:                                                              |

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**SOCIAL HISTORY**

Do you smoke? ☐ Yes ☐ No If yes, what? ☐ Cigarettes ☐ Cigars ☐ Pipes ☐ Other \_\_\_\_\_ # per day: \_\_\_\_\_  
Have you ever smoked? ☐ Yes ☐ No Started at age: \_\_\_\_\_ Quit at age: \_\_\_\_\_ Interested in quitting? ☐ Yes ☐ No Do you drink alcohol? ☐ Yes ☐ No If yes, what? ☐ Wine ☐ Liquor ☐ Cocktails ☐ Beer ☐ Other \_\_\_\_\_ How often? ☐ Daily ☐ Weekend ☐ Socially  
Drinks per day ☐ 1-2 ☐ 3-5 ☐ >5  
Started at age: \_\_\_\_\_ Quit at age: \_\_\_\_\_

Children: ☐ Yes ☐ No If yes, how many? \_\_\_\_\_

Relationship Status: ☐ Single ☐ Divorced ☐ Married ☐ Partnered  
Occupation Status: ☐ Student ☐ Employed full-time ☐ Retired ☐ Employed part-time ☐ Homemaker ☐ Unemployed ☐ Unable to work

Occupational exposure to hazardous material? ☐ Yes ☐ No If yes, ☐ Radiation ☐ Chemicals ☐ Other Particles \_\_\_\_\_

**HEALTH MAINTENANCE HISTORY**

Last GYN exam: \_\_\_\_\_ ☐ EGD date: \_\_\_\_\_ Last colonoscopy or CRC screening test: \_\_\_\_\_  
Last dental exam: \_\_\_\_\_ ☐ EKG/Echo date: \_\_\_\_\_  
Last mammogram: \_\_\_\_\_ ☐ Last CT chest lung cancer screening (if smoker): \_\_\_\_\_

Do you receive prophylactic vaccines? ☐ Yes ☐ No List vaccine and dates received:  
Are you up to date with recommended vaccines? ☐ Yes ☐ No

**FAMILY HISTORY**

Any bleeding or clotting disorders in family member? ☐ Yes ☐ No  
If yes, which relative(s) and what type? \_\_\_\_\_  
Have any family members had genetic testing? ☐ Yes ☐ No  
If yes, which relative(s) and what were the results? \_\_\_\_\_

| Relative             | Disease | Cancer type if applicable | Age at Diagnosis | Cause of Death |
|----------------------|---------|---------------------------|------------------|----------------|
| Father               |         |                           |                  |                |
| Mother               |         |                           |                  |                |
| Siblings             |         |                           |                  |                |
| Child(ren)           |         |                           |                  |                |
| Paternal Grandfather |         |                           |                  |                |
| Paternal Grandmother |         |                           |                  |                |
| Maternal Grandfather |         |                           |                  |                |
| Maternal Grandmother |         |                           |                  |                |
| Other Relatives      |         |                           |                  |                |

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**CURRENT SYMPTOMS**

General

- ☐ Change in appetite
- ☐ Change in weight
- ☐ Fatigue
- ☐ Generalized weakness
- ☐ Fever
- ☐ Chills
- ☐ Night sweats
- ☐ Frequent colds

Eyes

- ☐ Glasses/contacts
- ☐ Change in vision
- ☐ Eye pain
- ☐ Double vision

Ears, nose, mouth, throat

- ☐ Hearing problems
- ☐ Nose bleeds
- ☐ Sinus trouble
- ☐ Postnasal drip
- ☐ Dental problems
- ☐ Sore mouth, tongue or lips
- ☐ Hoarseness
- ☐ Sore throat
- ☐ Bleeding gums

Heart

- ☐ Chest pain
- ☐ Irregular heartbeat
- ☐ Swollen feet or ankles

Lungs

- ☐ Persistent cough
- ☐ Coughing up blood
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Sputum or phlegm production
- ☐ Difficulty breathing when lying flat

Musculoskeletal

- ☐ Joint pain/arthritis
- ☐ Muscle or joint weakness
- ☐ Back pain
- ☐ Bone pain
- ☐ Muscle aches

Genitourinary

- ☐ Excessive nighttime urination
- ☐ Excessive daytime urination
- ☐ Slow starting or stopping
- ☐ Urine leakage
- ☐ Pain/burning with urination
- ☐ Pelvic pain
- ☐ Blood in the urine

Men only

- ☐ Prostate infections
- ☐ Impotence

Women only

- ☐ Vaginal discharge
- ☐ Vaginal bleeding
- ☐ Painful intercourse
- ☐ Cramping

Digestive

- ☐ Difficulty swallowing
- ☐ Frequent heartburn
- ☐ Belching or excess gas
- ☐ Abdominal pain
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Black stools
- ☐ Change in bowel habits
- ☐ Rectal bleeding
- ☐ Hemorrhoids

Endocrine

- ☐ Hot flashes
- ☐ Heat intolerance
- ☐ Cold intolerance

Immunologic

- ☐ Severe allergic reactions
- ☐ Frequent or severe infections
- ☐ Pollen allergies/hay fever

Skin

- ☐ Rash, hives or itching
- ☐ Change in color
- ☐ Change in mole or wart
- ☐ A sore that won't heal

Nervous system

- ☐ Headaches
- ☐ Dizziness or vertigo
- ☐ Fainting
- ☐ Convulsions, seizures or tremors
- ☐ Memory loss
- ☐ Poor coordination
- ☐ Weakness of arms or legs
- ☐ Numbness in arms or legs

Blood disorders

- ☐ Easy bruising
- ☐ Abnormal bleeding
- ☐ Enlarged lymph nodes
- ☐ Blood transfusion(s)

Psychiatric

- ☐ Anxiety disorder
- ☐ Major depression
- ☐ Trouble sleeping/insomnia
- ☐ Work/family stress

Other

- ☐ \_\_\_\_\_
- ☐ \_\_\_\_\_
- ☐ \_\_\_\_\_
- ☐ \_\_\_\_\_