

REVIEW OF SYMPTOMS CONTINUED

Please answer the following questions regarding symptoms since your last visit or procedure

Gastrointestinal:

- Yes No Difficulty swallowing _____
- Yes No Heartburn _____
- Yes No Severe abdominal pain _____
- Yes No Recurrent nausea or vomiting _____
- Yes No Unexplained constipation _____
- Yes No Persistent diarrhea _____
- Yes No Black stools or blood in stools _____
- Yes No Red blood per rectum _____

Genitourinary/Sexual:

- Yes No Frequency or urgency urinating _____
- Yes No Do you get up at night to urinate more than two times a night _____
- Yes No Pain when urinating _____
- Yes No Lose urine when coughing/sneezing _____
- Yes No Blood in urine _____
- Yes No Pain in back _____
- Yes No **Men:** Erectile Dysfunction _____
- Yes No **Women:** Menopausal Symptoms _____

Musculoskeletal:

- Yes No Joint pain/stiffness/swelling _____
- Yes No Deformity of joint _____
- Yes No Muscle pain _____

Neurologic:

- Yes No Weakness/numbness on one side of the body _____
- Yes No Temporary loss of speech _____
- Yes No Temporary loss of vision _____
- Yes No Any coordination problems _____
- Yes No Loss of muscle function _____
- Yes No Double vision _____
- Yes No Inability to walk _____

Psychiatric:

- Yes No Memory Disorder problems _____
- Yes No Felt depressed or sad over 2 wks. _____
- Yes No Felt anxious over 2 wks. _____

Endocrine:

- Yes No Increased urination _____
- Yes No Increased thirst _____
- Yes No Increased eating _____
- Yes No New heat intolerance _____
- Yes No New cold intolerance _____

Hematologic:

- Yes No Easy bruising _____
- Yes No Any blood transfusion reactions _____
- Yes No Any abnormal bleeding _____

Skin:

- Yes No Any skin rash _____
- Yes No **Are you experiencing any problems that are not listed above** _____

Vital Signs: Weight _____ Right BP _____ Height _____ Left BP _____ Heart Rate _____

Nursing Notes: _____

Reviewed by: _____ RN Date/Time _____

Reviewed by: _____ MD Date/Time _____

PLACE LABEL HERE.



0300003

IF LABEL NOT AVAILABLE, WRITE IN PT NAME & MR#

NUCLEAR MEDICINE – INITIAL VISIT SCREENING TOOL

Please complete all pages of this form and bring it with you to your appointment.

It will help us serve you better.

Name _____ Birthdate/Age _____

Name of Local Family Care Physician _____ Last visit with Family Physician _____

Reason for your visit today _____

MEDICAL PROBLEMS – check the boxes that apply and enter year began.

- | | | | |
|--|----------------------|---|----------------------|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Anemia _____ | Year Diagnosed _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No Hives/Eczema _____ | Year Diagnosed _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Angina (chest pain) _____ | | <input type="checkbox"/> Yes <input type="checkbox"/> No Irregular Heart Rhythm _____ | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Arthritis _____ | | <input type="checkbox"/> Yes <input type="checkbox"/> No Kidney Disease _____ | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Asthma/Hayfever _____ | | <input type="checkbox"/> Yes <input type="checkbox"/> No Liver Disease _____ | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Blood Transfusions _____ | | <input type="checkbox"/> Yes <input type="checkbox"/> No Lung Disease _____ | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Cancer _____ | | <input type="checkbox"/> Yes <input type="checkbox"/> No Migraine Headaches _____ | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Colitis _____ | | <input type="checkbox"/> Yes <input type="checkbox"/> No Pneumonia _____ | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Depression _____ | | <input type="checkbox"/> Yes <input type="checkbox"/> No Peripheral Vascular _____ | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes _____ | | <input type="checkbox"/> Yes <input type="checkbox"/> No Disease _____ | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Drug Abuse/Alcohol _____ | | <input type="checkbox"/> Yes <input type="checkbox"/> No Seizures _____ | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Abuse _____ | | <input type="checkbox"/> Yes <input type="checkbox"/> No Stroke _____ | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Emphysema _____ | | <input type="checkbox"/> Yes <input type="checkbox"/> No Thyroid Disease _____ | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Gout _____ | | <input type="checkbox"/> Yes <input type="checkbox"/> No Tuberculosis _____ | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Heart Attack _____ | | <input type="checkbox"/> Yes <input type="checkbox"/> No Ulcers _____ | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Heart Failure _____ | | <input type="checkbox"/> Yes <input type="checkbox"/> No Urinary Tract Infections _____ | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Hepatitis _____ | | <input type="checkbox"/> Yes <input type="checkbox"/> No Venereal Disease _____ | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No High Blood Pressure _____ | | <input type="checkbox"/> Yes <input type="checkbox"/> No Other _____ | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No High Cholesterol _____ | | | |

SURGERIES – check the boxes and enter the year for surgeries you have had.

- | | | | |
|---|------------|---|------------|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Aneurysm Repair _____ | Year _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No Heart Valve Surgery _____ | Year _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Back Surgery _____ | | <input type="checkbox"/> Yes <input type="checkbox"/> No Hysterectomy _____ | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Carotid Artery _____ | | <input type="checkbox"/> Yes <input type="checkbox"/> No Lung Surgery _____ | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Cesarean Section _____ | | <input type="checkbox"/> Yes <input type="checkbox"/> No Organ Transplant _____ | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No D&C _____ | | <input type="checkbox"/> Yes <input type="checkbox"/> No Tubes Tied _____ | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Gall Bladder Out _____ | | <input type="checkbox"/> Yes <input type="checkbox"/> No Varicose Veins _____ | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Heart Bypass _____ | | <input type="checkbox"/> Yes <input type="checkbox"/> No Vascular (aorta or legs) _____ | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Heart Pacemaker _____ | | <input type="checkbox"/> Yes <input type="checkbox"/> No Other _____ | |

PREVIOUS PROCEDURES – check the boxes that apply (include date of test and results)

- Exercise/Peripheral Vascular Studies _____
- Cardiac Catheterization/Arteriogram _____
- MRI, CT, Ultrasound _____
- PTC, PNC, TIPS, Embolization _____

INJURIES/ACCIDENTS – describe and list the year it occurred (please include broken bones)

LIST ALL CURRENT MEDICATIONS INCLUDING OVER THE COUNTER/VITAMINS/HERBALS

| REGULAR MEDICATIONS/DOSE | HOW OFTEN | REGULAR MEDICATIONS/DOSE | HOW OFTEN |
|--------------------------|-----------|--------------------------|-----------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

ALLERGIES TO MEDICATIONS - List the medication name and describe any reaction you have to it.

None Known _____

CONTRAST (X-Ray or IVP Dye) _____

IMMUNIZATIONS (Please enter the year of last immunization)

Flu vaccine _____ Pneumonia _____

DATE OF LAST CHOLESTEROL LEVEL: _____ **Result:** Total _____ Triglycerides _____ LDL _____ HDL _____

GYNECOLOGY/OBSTETRIC (women only) – check those that apply Have reached menopause

Have bleeding problem Currently pregnant Last Monthly Period _____ Tubal Hysterectomy

PERSONAL SOCIAL HISTORY

Single Married Divorced Widowed

Education (Check highest grade completed) Elementary High School College Graduate

Occupation _____

Religion/Faith _____

| Name of Children | Age | Health or Medical Problem |
|------------------|-------|---------------------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

TOBACCO Including Cigars, Snuff, & Chewing Tobacco

Never

Former: Year quit _____ # of years _____ Packs per day _____

Current # of years _____ Packs per day _____

ALCOHOL Indicate drinks per week Never Beer _____ Wine _____ Liquor _____

Have you ever had a legal, personal or health problem related to alcohol? Yes No

EXERCISE Never Type of exercise _____ Frequency _____

Do you feel safe in your living situation? Yes No (Falls, violence) Comments: _____

Do you have a Living Will? Yes No Does UVA have a copy? Yes No

FAMILY MEDICAL HISTORY

Mother's Name _____ Alive and Well Died Age _____

Cause of Death: _____

General Health/Innnesses/Heart Disease: _____

Father's Name _____ Alive and Well Died Age _____

Cause of Death: _____

General Health/Innnesses/Heart Disease: _____

Names of Brothers & Sisters

_____ Alive and Well Heart Disease Died Age _____ Cause _____

_____ Alive and Well Heart Disease Died Age _____ Cause _____

_____ Alive and Well Heart Disease Died Age _____ Cause _____

_____ Alive and Well Heart Disease Died Age _____ Cause _____

_____ Alive and Well Heart Disease Died Age _____ Cause _____



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PLACE LABEL HERE.

IF LABEL NOT AVAILABLE, WRITE IN PT NAME & MR#

NUCLEAR MEDICINE – INITIAL VISIT SCREENING TOOL

REVIEW OF SYMPTOMS

Please answer the following questions regarding symptoms since your *last visit or procedure*

General:

Comments:

Yes No Weight change _____

Yes No Loss of appetite _____

Yes No Weakness _____

Yes No Fever, chills _____

Yes No Tiredness w/o apparent reason _____

Yes No Night sweats _____

Head:

Yes No Severe headaches _____

Yes No Head injury _____

Eyes:

Yes No Glaucoma _____

Yes No Cataracts _____

Ears:

Yes No Abnormal noise _____

Yes No Dizziness _____

Nose and Sinuses:

Yes No Sinus pain _____

Mouth and Throat:

Yes No Persistent hoarseness _____

Yes No Altered taste _____

Last dental visit _____

Cardiovascular:

Yes No Chest pain _____

Yes No Shortness of breath on exertion _____

Yes No Shortness of breath lying flat _____

Yes No Wake up at night short of breath _____

Yes No Swelling of hands, feet, or ankle _____

Yes No Palpitations or fluttering of heart _____

Yes No Dizziness on change of position _____

Yes No Fainting spells _____

Respiratory:

Yes No Wheezing _____

Yes No Short of breath at rest _____

Yes No Cough _____

Yes No Sputum production _____

Yes No Cough up blood _____

Yes No Exposure to toxins/asbestos _____

Peripheral Vascular:

Yes No Numbness or tingling of hands or feet _____

Yes No Discoloration of feet or hands _____

Yes No Enlarged veins in legs _____

Yes No Leg cramps when walking or at rest _____

Yes No Blood clot in the legs _____

Yes No Ulcers of hands or feet _____