Gynecologic Oncology
OF TALLAHASSEE
A Division of Florida Cancer Specialists

Patient Name: _____ **DOB:** _____

Review of Symptoms: (Please check any **current** symptoms you have.)

General:
- ❑ Weight Loss

How much _____
Over what time period _____
- ❑ Fevers
- ❑ Max temp _____
- ❑ Chills
- ❑ Night sweats
- ❑ Fatigue

Eyes:
- ❑ Wear Glasses/Contact Lenses
- ❑ Blurred Vision
- ❑ Double Vision

Ears, Nose, Throat:
- ❑ Hard of Hearing or Deaf
- ❑ Ringing in Ears
- ❑ Enlarged Lymph nodes
- ❑ Chronic Sinus Problems
- ❑ Sore Throat
- ❑ Mouth Pain/Sores

Changes/Difficulty In:
- ❑ Taste
- ❑ Smell

Cardiovascular:
- ❑ Chest Pain/Angina Pectoris
- ❑ Palpitations/Heart Murmur
- ❑ Irregular Heart Beat/Pressure

Respiratory:
- ❑ Chronic or Frequent Cough
- ❑ Bloody Sputum
- ❑ Shortness of Breath

Skin:
- ❑ Rashes or Itching
- ❑ Change in Skin Color or Moles
- ❑ Varicose Veins
- ❑ Skin Cancer

Gastrointestinal:
- ❑ Difficult or Painful Swallowing
- ❑ Abdominal Pain
- ❑ Nausea
- ❑ Vomiting
- ❑ Heartburn
- ❑ Indigestion
- ❑ Lump or Sensation in Throat
- ❑ Food Sticking
- ❑ Bloating
- ❑ Belching
- ❑ Diarrhea
- ❑ Constipation
- ❑ Rectal Bleeding
- ❑ Black or Tarry Stool
- ❑ Hidden Blood in Stool
- ❑ Excessive Rectal Gas/Flatus
- ❑ Loss of Stool/Fecal Accident
- ❑ Poor Appetite
- ❑ Jaundice

Genitourinary:
- ❑ Kidney Stones
- ❑ Pelvic Pain
- ❑ Incontinence
- ❑ Burning or Pain on Urination
- ❑ Blood in Urine
- ❑ Difficult Urination
- ❑ Men: Prostate Problems

Musculoskeletal:
- ❑ Joint Pain/Arthritis
- ❑ Muscle or Joint Weakness
- ❑ Back Pain
- ❑ Bone Pain
- ❑ Muscle Aches

Neurological:
- ❑ Numbness/Tingling
- ❑ Arm or Leg Weakness
- ❑ Light-Headed/Dizzy/Fainting Spells
- ❑ Tremors/Headaches

Psychiatric:
- ❑ Anxiety/Agitation
- ❑ Depression
- ❑ Crying for No Reason
- ❑ Insomnia
- ❑ Alcoholism
- ❑ Drug Problem

Hematologic:
- ❑ Easy Bruising
- ❑ Gum or Nose Bleeding
- ❑ Blood Transfusions

Endocrine:
- ❑ Heat or Cold Intolerance
- ❑ Excessive Skin Dryness
- ❑ Excessive Thirst
- ❑ Excessive Urination
- ❑ Weight Problem
- ❑ Hot Flashes

Breast:
- ❑ Rashes or Itching
- ❑ Changing in Skin Color
- ❑ Varicose Veins
- ❑ Skin Cancer
- ❑ Breast Pain/Lump
- ❑ Breast Discharge
- ❑ Breast Rash

Allergies/Immunology:
- ❑ History of Allergies
- ❑ Chronic Infections

FLORIDA CANCER SPECIALISTS & Research Institute

Patient Name: _____

MRN # _____

CONSENT FOR PELVIC EXAMINATION

The pelvic examination is integral to a complete gynecologic and pelvic assessment. It allows the health care provider to evaluate and perform a series of tasks that comprise an examination, under anesthesia or fully conscious, of the entire female genital tract including the vulva, vagina, cervix, uterus, fallopian tubes, ovaries, rectum, anus, or external pelvic tissue or organs or an entire male examination of testicles, prostate, penis, rectum, anus or external pelvic tissue and organs, using any combination of modalities, which may include, but need not be limited to, the healthcare provider's gloved hand or instrumentation.

Cancers or other masses can be found or assessed over time. Some lesions can be found on this exam that are not visible on CT or PET scans or other tests. Prolapse can be diagnosed. The part of this exam using a speculum to hold the walls of the vagina open is necessary to perform a Pap test, visualize the vagina and cervix and other structures, or to take biopsy. The rectum and anus cannot be properly evaluated without an exam. If a pelvic exam is not performed, these organs cannot be evaluated, and a pap test cannot be performed. The prostate cannot be effectively evaluated without an exam. Your healthcare providers will do everything possible to minimize discomfort during this exam.

I have been given the opportunity to ask questions regarding a pelvic examination and have had all of my questions answered in a satisfactory manner. I understand the information presented and discussed with me.

I, _____, **GIVE CONSENT** to my healthcare provider, _____, at Florida Cancer Specialists to perform a pelvic examination. This consent is being given for the office visit today, and will be valid for one year, unless consent is verbally withdrawn.

To decline the examination:

I, _____, **REFUSE TO** give consent to my health care provider at Florida Cancer Specialists to perform a pelvic examination. I understand that such refusal prevents a full assessment and complete exam, and failure to comply with recommendations may compromise my care.

_____ _____

Patient Name (Print) Signature of Patient or Legal Representative

_____ _____

Relationship to Patient Date/Time

_____

FCS Witness (print name)