TEXAS ONCOLOGY

New Patient & Family History

Today's Date:_____ Patient Name:_____ (Last / First / Middle or Maiden) Date of Birth:_____

Gender: ☐Male ☐Female Marital Status: (Please check one) ☐ Married ☐ Single ☐Divorce ☐Widow ☐Other:_____

Telephone (1st call): (____)_____ Telephone (2nd call): (____)_____

Referring Physician:_____ (Name / Address / City / State / Zip Code)

Primary Care Physician:_____ (Name / Address / City / State / Zip Code)

Number of Children:_____ Ages:_____

What is your primary language? _____

Who lives with you? (Please check all that apply) ☐ I live alone ☐Spouse ☐Children ☐Parents ☐Friend ☐Other:_____

Who helps at home?_____

Person(s) with your Medical Record Access: _____ (Name / Relationship / Telephone)

Have you executed a Durable Power of Attorney, Directive to Physician and/or Living Will? ☐Yes ☐No

Would you like additional information regarding these documents? ☐Yes ☐No

If you have signed one of these legal documents then please speak to the nurse regarding your decisions and bring a copy with you to your appointment

Do you have daily transportation available? ☐Yes ☐No

I am currently: Working: ☐Yes ☐No Work Schedule is: ☐Full-time ☐Part-time ☐Sick Leave ☐Retired ☐Disability

What type of work do you currently do or have done?_____

Do you use any of the following? (Please check all that apply)

Alcohol: ☐Yes ☐No What type?_____ How much?_____ How often?_____ If quit, when?_____

Tobacco: ☐Yes ☐No What type?_____ How much?_____ How often?_____ If quit, when?_____

Caffeine: ☐Yes ☐No What type?_____ How much?_____ How often?_____ If quit, when?_____

Recreational Drugs: ☐Yes ☐No What type?_____ How much?_____ How often?_____ If quit, when?_____

Sunscreen: ☐Yes ☐No

How much time do you spend exercising each week?_____ What type of exercise?_____

Do you need to use any of the following? (Please check all that apply) ☐Cane ☐Walker ☐Wheelchair ☐Oxygen

☐Other: _____

Do you do monthly self-exams? (Please check all that apply) Skin cancer: ☐Skin ☐Mole ☐Other:_____

Female: Breast ☐Yes ☐No Have you ever been trained properly for breast self-exam? ☐Yes ☐No

Male: Testicles ☐Yes ☐No Have you ever been trained properly for testicular self-exam? ☐Yes ☐No

Are you diabetic? ☐Yes ☐No If yes, what type:_____

If yes, how is it controlled: ☐Diet ☐Oral Medications ☐Insulin ☐Other: _____

Are you claustrophobic (fearful of being in enclosed or narrow spaces): ☐Yes ☐No If yes, how is it controlled:_____

Reproductive History:

Female: Number of pregnancies:_____ Number of children: _____ Age at first pregnancy:_____

Did you breast feed: ☐Yes ☐No If yes, how many months (approximate): _____

Age at first period:_____ Age at menopause: _____ Age at last period:_____

Hysterectomy: ☐Yes ☐No Ovaries intact: ☐Yes ☐No If *no*, please explain:_____

Hormone use: ☐Yes ☐No Sex Drive: ☐Yes ☐No Method of birth control:_____

Male: Impotence (Erectile Dysfunction): ☐Yes ☐No Sex Drive: ☐Yes ☐No

Please return completed form to the appropriate physician's office.

CONFIDENTIAL

TEXAS ONCOLOGY

New Patient & Family History

Today's Date:_____ Patient Name:_____ Date of Birth:_____
Last First Middle or Maiden

What is your understanding of why you are being seen:_____

Additional Medical Condition History

(If additional space is needed then please copy this page)

Diagnosis / Condition	Physician Name	Physician Office #	Date Occurred

Surgery / Injury / Hospitalization	Physician Name / Hospital	Physician Office #	Date Occurred

Please list the names of hospital(s) or clinic(s) where you had x-rays in the last six months:_____

Preventive Health Maintenance

(Please provide dates for each or answer "none")

Female:
Last mammogram:_____
Last pap smear:_____
Last colonoscopy:_____
Last bone density scan:_____
Last pneumonia vaccine:_____

Male:
Last colonoscopy:_____
Last prostate exam:_____
Last PSA screening:_____
Last pneumonia vaccine:_____

Is there any family history of cancer, blood disorders, cardiovascular disease, or other medical problems? If so, record below

(M) = Maternal (P) = Paternal (If additional space is needed then please copy this page)

Family Member	Living Status	Medical Problem	Family Member	Living Status	Medical Problem
Mother	☐Living ☐Deceased		Grandmother (P)	☐Living ☐Deceased	
Father	☐Living ☐Deceased		Grandfather (P)	☐Living ☐Deceased	
Children	☐Living ☐Deceased		Aunt(s)	☐Living ☐Deceased	
Brother(s)	☐Living ☐Deceased		Uncle(s)	☐Living ☐Deceased	
Sister(s)	☐Living ☐Deceased		Cousin(s)	☐Living ☐Deceased	
Grandmother (M)	☐Living ☐Deceased		Other:		
Grandfather (M)	☐Living ☐Deceased		Other:		

Patient Signature:_____ Date:_____

If someone other than the patient completed this form, please give name & relationship:_____
Name Relationship

Nurse Name:_____ Signature:_____ Date Reviewed:_____

Please return completed form to the appropriate physician's office.

TEXAS ONCOLOGY

Medication and Allergy List

Today's Date:_____

Patient Name:_____ _____ _____ _____
Last First Middle or Maiden Date of Birth

Please list all prescriptions, vitamins, herbs, and over-the-counter medications that you are currently taking and/or bring your medications with you to your appointment.

(If additional space is needed then please copy this page)

Medication	Strength	Dose	How many times a day

** Allergies **

Medication (Include prescription, over-the-counter and/or vitamins)	Describe Reaction

Have you ever had an allergic reaction to: ❑ Contrast Dye ❑ Iodine ❑ Shell Fish

What type of reaction did you have: ❑ Hives ❑ Shortness of breath ❑ Other:_____

Additional Comments and/or Information:_____

Pharmacy Information

_____ ( ) _____
Pharmacy Name Phone Number

_____
Address City State Zip Code

Please return completed form to the appropriate physician's office.

Patient Name: _____ **Account #**_____
Please Print TXO will Complete

Why are we asking these questions? In 2009 Congress passed the HITECH Act to create uniformity among electronic health records. Asking for your language ensures you and your healthcare providers will be able to communicate clearly. We will be asking about race & ethnicity because some groups are at a higher risk of developing certain diseases. This information will be updated in your medical record and will remain confidential.

Circle Preferred Language

AMERICAN SIGN LANGUAGE	FRENCH CANADIAN	LAO	SWAHILI
ARABIC	GERMAN	MAORI	SWEDISH
ARMENIAN	GREEK	MIEN	TAGALOG
BRAZILIAN PORTUGUESE	GUJARATI	NAVAJO	THAI
CHINESE	HEBREW	NORWEGIAN	TIGRINYA
CHINESE (CANTON)	HINDI	OROMO	TURKISH
CHINESE MANDARIN	HMONG	OTHER	UNDEFINED
CROATIAN	HUNGARIAN	PERSIAN	URDU
DANISH	INDIAN	POLISH	VIETNAMESE
ENGLISH	INDONESIAN	PORTUGUESE	VISAYAN
FARSI	ITALIAN	RUSSIAN	YIDDISH
FILIPINO	JAPANESE	SLOVAK	
FINNISH	KHMER	SOMALI	
FRENCH	KOREAN	SPANISH	

Circle Ethnicity HISPANIC OR LATINO NOT HISPANIC OR LATINO

Circle Preferred Method of Contact **H**ome phone **C**ell phone **W**ork phone Email Mail Home Address

Phone number not previous provided _____ H C W (circle type)

Email address: _____

CIRCLE RACE

AFRICAN AMERICAN	HMONG	OTHER ASIAN INCLUDING ASIAN NOS AND ORIENTAL NOS
ASIAN INDIAN PAKISTANI SRI LANKAN	JAPANESE	PACIFIC ISLANDER NOS
CAUCASIAN	KAMPUCHEAN CAMBODIAN	POLYNESIAN NOS
CHAMORRAN	KOREAN	SAMOAN
CHINESE	LAOTIAN	TAHITIAN
FIJI ISLANDER	MELANESIAN NOS	THAI
FILIPINO	MICRONESIAN NOS	TONGAN
GUAMANIAN NOS	NATIVE AMERICAN	VIETNAMESE
HAWAIIAN	NEW GUINEAN	UNKNOWN
HISPANIC	OTHER ASIAN INCLUDING ASIAN NOS AND ORIENTAL NOS	OTHER

Options/Values were selected by HITECH Act and Texas State Tumor Registry.

TEXAS ONCOLOGY

More breakthroughs. More victories.®

PRESCRIPTION HISTORY CONSENT

I voluntarily consent to provide Texas Oncology access to and use of my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes. I understand that my prescription history (which includes but is not limited to prescriptions, labs, and other health care drug historical information) from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions dating back for several years.

I acknowledge that Texas Oncology may use health information exchange systems to electronically transmit, receive and/or access my prescription history.

I understand that this Prescription History Consent will be valid and remain in effect as long as I attend or receive services from Texas Oncology, unless revoked by me in writing with such written notice provided to each practice site I attend or from which I receive services.

I certify that I have read this form or it has been read to me.

Date: _____

Print Name (Patient): _____ **DOB:** _____

Signature of Patient/Legally Authorized Representative:

_____

Relationship to Patient (if Patient not signing):

_____

For patients requiring translation or verbal reading of this document, the person Reading or translating should document and sign below:

Reader/Translator Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

I acknowledge that the Texas Oncology Notice of Privacy Practices provides information about how the practice and its workforce may use and/or disclose protected health information about me for treatment, payment, health care operations, and as otherwise allowed by law. I understand that Texas Oncology cannot be responsible for use or re-disclosure of information by third parties.

I acknowledge I have received a paper copy of the Texas Oncology Notice of Privacy Practices.

_____ **(Patient's Initials)**

User Electronic Mail Authorization Form
Patient Portal: My Care Plus

My Care Plus, the Patient Portal (the "Portal") offers convenient and secure access to your personal health record. As the patient, you are in control of your Portal record: we will not activate your personal account unless you authorize us to do so.

Because personal identifying information and other information about your health and medical history is available via the Portal, it is very important that you keep your password private. Do not share your password with anyone or write it in a place easily accessible to others.

If you choose not to execute this User Electronic Mail Authorization Form, you will not be able to access the Portal. If you choose to submit this form, you understand you are consenting for us to email you a unique link that you will use to create a password in order to access the Portal. **Please look for an email from My Care Plus promptly after submitting this form.** For your protection, the link is designed to expire quickly if not used. If you should change email addresses, please contact your physician's office in order to provide your new email contact information so that you will continue to receive updates and other pertinent information about the Portal or your record. Please choose an email address that will not be subject to access by anyone you do not trust.

If you wish to discontinue utilizing the Portal, please contact your physician's office.

Terms

You are receiving access to the Portal, the terms and conditions of the Portal shall apply to this User Electronic Mail Authorization Form. Please write legibly.

_____
Patient Name
(First Name, Middle Initial, Last Name)

_____
Email Address of Patient/Authorized User

_____
Date of Birth

_____
Choose A User ID

Authorized User is:

☐ Patient
☐ Patient's Designee

_____
Patient's Designee's Name (Printed)

_____
Patient's Designee's Signature

_____
Patient's Signature

_____
Date

STAFF USE:
Account #_____
Decline Reason
__No E-mail Address
__No Computer/Internet
__Not Interested

TEXAS BREAST SPECIALISTS

Higher Standards • Greater Hope

This form was designed to reduce the duplication of medical histories taken by many of the physicians you may encounter in the course of your breast care. Please complete the following questions using a blue or black pen. Leave questions blank if you are unsure how to answer the question; a medical staff member will be reviewing the form with you before you see the physician. Thank you for taking the time to fill out this form.

Ethnic Origin

❑ Asian American ❑ African American ❑ Caucasian ❑ Hispanic ❑ Ashkenazi Jewish Ancestry
❑ Other _____

Referral Information

Who referred you to our office? ❑ Doctor ❑ Family ❑ Friend ❑ Self ❑ Internet

Please specify the person's name (if applicable): _____

Main Reason for Visit (please check only one)

❑ Abnormal mammogram ❑ Breast Pain ❑ Breast Lump ❑ Other: _____

Breast lump, pain, or "other" first found by: ❑ Me ❑ Doctor ❑ Mammogram

Are You Currently Having Any of the Following Problems?

1. Lumps in breast: ❑ No ❑ Right ❑ Left ❑ Bilateral Since when? _____
   How did you find the lump? _____
2. Nipple discharge: ❑ No ❑ Right ❑ Left ❑ Bilateral Since when? _____
   Method of detection: ❑ Spontaneous ❑ Expressed
   Color: ❑ Brown ❑ Green ❑ Red ❑ Clear ❑ White ❑ _____
3. Breast tenderness/pain: ❑ No ❑ Right ❑ Left ❑ Bilateral Since when? _____
   My breast pain is: ❑ Continuous ❑ On and Off
4. Breast redness or swelling: ❑ No ❑ Right ❑ Left ❑ Bilateral Since when? _____
5. Prior breast injury: ❑ No ❑ Yes
6. Other complaints: _____

Last Name, First_____

Med Rec# _____ PCP_____

DOB:_____ Age _____ SC-02 Rev. 10/12

PATIENT ID STICKER

BREAST HEALTH QUESTIONNAIRE

Mammography Information

Have you had a previous mammogram? ❑ No ❑ Yes: Where? _____ When? ____/____/_____

Date of your first mammogram: ____/____/_____

Do you practice monthly breast self-exams? ❑ No ❑ Yes ❑ Sometimes

Ob/Gyn History

1. Have you had a hysterectomy? ❑ No ❑ Yes: Date of surgery: ____/____/_____
   Have your ovaries been removed? ❑ No ❑ One ❑ Both ❑ Unsure
2. Date of most recent pelvic exam: ____/____/_____
3. Are you pregnant? ❑ Unsure ❑ No ❑ Yes: Due date - ____/____/_____
4. Age at first menstrual cycle: _____
5. Are you still having periods? ❑ No ❑ Yes
6. Beginning date of last menstrual cycle: ____/____/_____
7. Which option best describes you:
   ❑ Have not had menopause yet ❑ Currently undergoing menopause
   ❑ Not sure if I have undergone menopause
   ❑ Already underwent menopause at age _____ *Type of Menopause:*
   ❑ Natural (periods just stopped by themselves)
   ❑ Surgical (ovaries and/or uterus removal)
8. Number of pregnancies: _____ Live-births: _____ Miscarriages/Abortions: _____
9. Age at first birth: _____ Age at last birth: _____
10. Did you ever breast feed? ❑ No ❑ Yes
    Age at first breast feeding: _____ How long (All the children together) ? _____months

Hormonal Medical History

1. Birth control pills: ❑ Never used ❑ On and Off use ❑ One long continuous period of use
   Age started: _____ Total years used: _____ Currently taking birth control pills? ❑ No ❑Yes
2. Hormone replacement therapy: ❑ Never used ❑ On and Off use ❑ One long continuous period of use
   Age started: _____ Total years used: _____ Are you currently taking hormones? ❑ No ❑ Yes
3. Infertility drugs/hormones: ❑ Never used ❑ On and Off use ❑One long continuous period of use
   Age started: _____ Age stopped: _____ Total months used: _____

Breast Surgery/Treatment History

1. Have you ever had a breast cyst(s)? ❑ No ❑ Right ❑ Left ❑ Both
   (Cysts are little sacs of fluid that are sometimes drained with a needle or may be seen on a mammogram or ultrasound.)

2. Number of needle biopsies you have had: ❑ None ❑ Right _____ ❑Left _____
(Needle biopsies are done in the office or in the breast imaging area.)
Type of needle biopsy: ❑ FNA ❑ Core ❑ Unsure

3. Number of surgical biopsies you have had: ❑ None ❑ Right _____ ❑ Left _____
(These involve cutting into your skin and are usually done in the operating room.)
Did the pathology show ADH (atypical ductal hyperplasia)?: ❑ No ❑ Yes ❑Unsure
Did the pathology show LCIS (lobular carcinoma in situ)?: ❑ No ❑ Yes ❑ Unsure
Age when first diagnosed with LCIS: _____

4. Have you ever been diagnosed with breast cancer? ❑ No ❑ Right ❑ Left ❑ Both
If yes, what type of surgery have you had for breast cancer? ❑ Removal of part of the breast
❑ Removal of the whole breast

Did you have reconstruction of the breast? ❑ No ❑ Yes

5. Have you ever had breast implants? ❑ No ❑ Yes: If yes, do you currently have implants? ❑ No ❑ Yes
Have you ever had silicone implants? ❑ No ❑ Yes
Any trouble with leaking implants? ❑ No ❑ Yes

Your Health History

1. Height: _____ feet _____ inches Weight: _____ pounds
2. Do you have a history of cancer other than breast cancer? ❑ No ❑ Yes
3. Have you ever had radiation therapy? ❑ No ❑ Yes
4. Have you ever had chemotherapy? ❑ No ❑ Yes
5. Do you have rheumatoid arthritis, lupus, Raynaud's or scleroderma? ❑ No ❑ Yes
6. Have you ever tested positive for AIDS or HIV? ❑ No ❑ Yes
7. Have you ever had general anesthesia? ❑ No ❑ Yes ❑ Unsure
If yes, were there any problems? ❑ No ❑ Yes
Do you have any family history of anesthesia problems? ❑ No ❑ Yes
8. Do you have any bleeding problems? ❑ No ❑ Yes
Are you taking any blood thinners? ❑ No ❑ Yes
Are you on daily aspirin? ❑ No ❑ Yes
9. Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widow
10. Highest level of education: ❑ High School ❑ Some College ❑ College Degree
11. Current employment status: ❑ Employed ❑ Retired ❑ Disabled ❑ Unemployed
Occupation: _____
Occupational toxin exposure history: _____
12. Caffeine (Regular use): ❑ coffee: _____ cups per day / week / month (circle one)
❑ NONE ❑ tea: _____ cups per day / week / month (circle one)
❑ soda: _____ cans per day / week / month (circle one)
❑ chocolate bar: _____ # per day / week / month (circle one)

13. Alcohol use: ❑ No ❑ Yes ❑ Occasionally (Less than 1 drink per week)
If yes, how many drinks per week? _____ Beer: _____ Wine: _____ Hard liquor: _____

14. Tobacco use (ever): ❑ No ❑ Yes ❑ Sporadic use
If yes, type: ❑ Cigarette ❑ Cigar ❑ Pipe ❑ Snuff ❑ Previous smoker
For cigarette smokers: _____ packs/day for _____ years

15. Have you ever taken street/recreational drugs? ❑ No ❑ Yes: specify - _____

Current medications and doses: _____

_____

_____

Drug or food allergies and reactions: _____

_____

_____

List all previous surgeries and dates: _____

_____

_____

List any medical problems and when they were diagnosed: _____

_____

_____

Family History

Please list all relatives including yourself, sons, daughters, mother, father, sisters, brothers, maternal and paternal aunts and uncles, and grandparents. Please include any major medical problems and, if they were diagnosed with cancer, ther age at that time. Circle "Living" or "Deceased" and note the current age, or age at death. If you are adopted, only include your family members that are genetically related to you.

Relationship	Living or Deceased	Age	Major Medical Problems	Type of Cancer(s) & Age at Diagnosis
	◯			
Daughter / Son	Living Deceased			
Daughter / Son	Living Deceased			
Daughter / Son	Living Deceased			

Mother	Living Deceased			
Father	Living Deceased			
Sibling	Living Deceased			
Sibling	Living Deceased			
Maternal Grandmother	Living Deceased			
Maternal Grandfather	Living Deceased			
Maternal Aunt / Uncle	Living Deceased			
Maternal Aunt / Uncle	Living Deceased			
Paternal Grandmother	Living Deceased			
Paternal Grandfather	Living Deceased			
Paternal Aunt / Uncle	Living Deceased			
Paternal Aunt / Uncle	Living Deceased			

(If additional space is needed, please write on back of this page in same format.)

I have fully reviewed the questionnaire and answered all questions truthfully and to the best of my knowledge. I am aware that my answers could affect my health care, or that of the patient for whom I am responsible:

_____ _____/_____/_____

Patient Signature Date

_____

Relationship *(if signature of parent or guardian)*

I have read and reviewed these results with the patient or responsible party.

_____ _____/_____/_____

Physician's Signature Date

REVIEW OF SYMPTOMS

Please review and check the appropriate box for any problems you may have now, or had in the past.

General
- ___ Unable to exercise
- ___ Weight Loss
- ___ Planned Weight Loss
- ___ Weight Gain
- ___ No recent weight gain/loss
- ___ Radiation Tx
- ___ Cancer Chemotherapy

Constitutional
- ___ Fever
- ___ Night Sweats
- ___ Loss of Appetite

Infection
- ___ Recent Cold/Flu
- ___ Tuberculosis

Mouth/Throat
- ___ Dental problems
- ___ Mouth Ulcers
- ___ Gum Bleeding/Pain
- ___ Hoarseness
- ___ Difficulty Swallowing

Cardiac
- ___ Heart Attack
- ___ Heart Disease
- ___ High Blood Pressure
- ___ Heart Murmur
- ___ Angina
- ___ Irregular Heart Beats
- ___ Short of Breath
- ___ Palpations
- ___ Mitral Valve Prolapse
- ___ Heart Failure
- ___ Tachycardia
- ___ Pericardial Effusion
- ___ Pacemaker
- ___ Aneurysm
- ___ Leg/Food Edema
- ___ Premature Ventricular Contractions

Respiratory
- ___ Chest Pain
- ___ Asthma
- ___ Chronic Cough
- ___ Pneumonia
- ___ Bronchitis
- ___ Breathing Problems
- ___ Wheezing
- ___ Emphysema
- ___ Short of Breath
- ___ Pleurisy

Gastro-Intestinal
- ___ Stomach Ulcers
- ___ Duodenal Ulcers
- ___ Hepatitis
- ___ Nausea
- ___ Diarrhea
- ___ Blood in Stool
- ___ Heartburn
- ___ Vomiting
- ___ Change in Bowel Habits
- ___ Colitis
- ___ Vomiting Blood
- ___ Intestinal Ulcers
- ___ Liver Problems
- ___ Jaundice
- ___ Hiatal Hernia
- ___ Hemorrhoids
- ___ Constipation
- ___ Irritable Bowel Syndrome

Genito-Urinary
- ___ Kidney Problems
- ___ Nephritis
- ___ Kidney Stone
- ___ Blood in Urine
- ___ Hot Flashes
- ___ Frequent Urination
- ___ Vaginal Discharge
- ___ UTI
- ___ Incontinence of Urine/Stool
- ___ Vaginal Spotting
- ___ Sexual Problems
- ___ Burning on Urination

Hematological/Lymphatic
- ___ Bleeding Tendency
- ___ Hemophilia
- ___ Easy Bruising
- ___ Anemia
- ___ Lymphoma
- ___ Blood Transfusion
- ___ Leukemia

- ___ Blood Clots
- ___ Red Cell Problems
- ___ Platelet Problems
- ___ Anticoagulants
- ___ Enlarged Lymph Nodes

Endocrine
- ___ Thyroid Problems
- ___ Steroid Use
- ___ Intolerance to Heat/Cold
- ___ Diabetes
- ___ Diabetes (Gestational)

Neurological
- ___ Nerve Injury
- ___ Paralysis
- ___ Headaches
- ___ Stroke
- ___ Seizure
- ___ Migraine Headaches
- ___ Speech Problems
- ___ Balance Problems
- ___ Fainting/Blackouts
- ___ TIA

Rheumatoid
- ___ Rheumatic Fever
- ___ Back Injury
- ___ Neck Injury
- ___ Herniated Disc
- ___ Arthritis
- ___ Rheumatoid Arthritis

Musculoskeletal
- ___ Leg cramps/pain
- ___ Weakness
- ___ Muscle Aches
- ___ Osteoporosis
- ___ Scoliosis

Psychiatric
- ___ Depression
- ___ Mental Problems
- ___ Sleep Problems
- ___ Anxiety

Oro-Gastric
- ___ Esophageal Ulcers

Eyes/Ears/Nose
- ___ Sinus Disease
- ___ Cataracts
- ___ Recent Visual Change
- ___ Nose Bleeds
- ___ Double Vision

- ___ Ringing in Ears
- ___ Hearing Loss

Skin
- ___ Rashes
- ___ Sores
- ___ Pigmented Moles
- ___ Hives
- ___ Skin Ulcers