LastName_____ **FirstName**_____

Date of Birth_____ **MRN**_____

What is the reason for your visit today? (Circle all that apply)

- ☐ Blood in Urine
- ☐ Erectile Dysfunction
- ☐ Incontinence (leakage of urine)
- ☐ Enlarged Prostate
- ☐ Urinary Tract Infection
- ☐ Elevated PSA
- ☐ Kidney Stones
- ☐ Urinary Problems
- ☐ Infertility
- ☐ Other_____

Do you have or have had any of the following medical problems

- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Stroke
- ☐ Asthma
- ☐ Hypothyroidism
- ☐ Cancer (please specify type)
- ☐ Diabetes
- ☐ Heart Attack
- ☐ COPD (chronic obstructive pulmonary disease)
- ☐ Depression
- ☐ Gout
- ☐ Bleeding disorder

Any other Medical Problems you are being treated for or have?

_____

_____

_____

_____

Please circle any of the surgeries listed below you have had with the approximate year.

- ☐ Hysterectomy _____
- ☐ Heart Valve Replacement _____
- ☐ Hip Replacement _____
- ☐ Hernia Repair _____
- ☐ Appendectomy _____
- ☐ Cardiac Bypass _____
- ☐ Knee Replacement _____
- ☐ Colon Resection _____
- ☐ Cholecystectomy _____
- ☐ Gastric Bypass _____

Are there any other surgeries you have had? Please list with the year

_____

_____

_____

_____

LastName_____ **FirstName**_____

Date of Birth_____ **MRN**_____

Are you allergic to any of the following?
(Please list the nature of the allergic reaction)

- ☐ **Penicillin**_____
- ☐ **Shellfish**_____
- ☐ **Ciprofloxacin**_____
- ☐ **Sulfa**_____
- ☐ **Iodine**_____
- ☐ **Other** _____

Do you have any other food or drug allergies please list them below

1_____
2_____
3_____
4_____

Do you smoke? NO YES
If yes how many cigarettes do you smoke each day? _____
Did you ever smoke? NO YES If YES when did you quit?_____
Do you drink alcohol? NO YES If YES how many drinks per day?_____
What is your occupation? _____

FAMILY HISTORY(parents,grandparents, siblings):

Has anybody in your family had cancer? NO YES | If Yes, who: _____
Has anybody in your family had prostate cancer? NO YES | If Yes, who: _____
Has anybody in your family had kidney cancer? NO YES | If Yes, who: _____
Has anybody in your family had bladder cancer? NO YES | If Yes, who: _____
Has anybody in your family had kidney stones? NO YES | If Yes, who: _____

What is your height?____**ft.** ____**in.**
What is your weight? _____**lbs.**

Are there any other serious medical conditions members of your family have had?

1_____
2_____
3_____
4_____

Please list any medications you take along with the dosages and how it is taken (*for example Aspirin 325 mg once daily at bedtime.* Include any over the counter medications, vitamins, or supplements you regularly take.

1_____ 4_____
2_____ 5_____
3_____ 6_____