



Date:

Full Name:

DOB:

Age:

Referring Urologist:

Primary Care Physician:

Other Physicians (you would like letters sent to):

Do you have a pacemaker or defibrillator? Y N

Have you had a hip replacement? Y N

Do you have any metal in your body? Y N If yes, where?

Have you ever had radiation before? Y N If yes, when and for what?

What conditions or diseases have you been diagnosed with or are being treated for, either now or in the past?
(i.e., heart disease, high blood pressure, diabetes, high cholesterol, inflammatory bowel disease such as ulcerative colitis or Crohn's disease, connective tissue diseases such as scleroderma, lupus, other cancers)

What surgeries have you undergone in the past?
(i.e., appendectomy – appendix, cholecystectomy – gall bladder, heart bypass, angioplasty, hip replacement)



Are there any conditions, diseases, or cancers that run in your family? Y N
If yes, in whom? What do/did they have? Approximately at what age were they diagnosed?

Please circle your race or ethnic origin (as defined by the EEOC):
White Black or African American Hispanic or Latino American Indian or Alaska Native
Asian Native Hawaiian or other Pacific Islander Prefer not to answer Other _____

Are you married, single, divorced, widowed?

Are you currently working or retired? What line of work are/were you in?

Do you currently smoke? Y N
If yes, how many packs of cigarettes per day? For how many years?
If no, have you smoked in the past? Y N If yes, when did you quit?

Do you drink alcohol? Y N If yes, regularly, socially, or occasionally?

What medications are you allergic to that you know of, if any?

What medications, including vitamins and herbs, are you currently taking?
(You may attach a list)

Have you recently been experiencing any of the following?

Unintended weight loss	Y	N
Loss of energy or extreme fatigue	Y	N
Loss of appetite	Y	N
Fevers or chills	Y	N
Atypical, unusual, or uncharacteristic headaches	Y	N
Changes in your vision (i.e., double vision)	Y	N
Decrease in or loss of hearing	Y	N
Loss of voice or hoarseness	Y	N
Chest pain	Y	N
Swelling of the arms or legs	Y	N
Shortness of breath	Y	N
Cough productive of phlegm or blood	Y	N
Abdominal pain	Y	N
Nausea or vomiting	Y	N
Persistent diarrhea or constipation	Y	N
Bright red or dark black tarry colored stools	Y	N
Joint or bone pain	Y	N
Loss of strength of one or both arms/hands or legs/feet	Y	N
Numbness or tingling (i.e., of the arms or legs)	Y	N
Trouble with memory, confusion, speech, coordination, walking	Y	N
Have you developed any new skin rashes	Y	N
Have you noticed swelling of any (lymph) glands	Y	N
Have you had any problems with bleeding (i.e., from the gums, etc.)	Y	N
Are there any other symptoms you have been experiencing recently?	Y	N
If yes, please list or explain...		

In terms of your urinary habits, please answer the following

When you feel the need to urinate, is there a strong sense of urgency? (i.e., are you unable to hold or postpone the need to urinate?)	Y	N				
Do you find yourself pushing or straining to begin urinating?	Y	N				
Do you feel that the urinary stream is weak, slow, or interrupted? (i.e., does the flow start and stop or is it slower than usual?)	Y	N				
Do you have trouble completely emptying your bladder? (i.e., does the flow of urination stop prematurely?)	Y	N				
Do you experience burning or bleeding with urination?	Y	N				
Are you able to have an erection sufficient for intercourse?	Y	N				
How many times do you wake up at night just to urinate?	0	1	2	3	4	5

For staff only:

Height:

Weight:

Temp: