

ALLERGIES: (Medications, I.V. Contrast, Foods, Environment, etc.)

YES NO If YES , Please List Below

FAMILY HISTORY: (Check if you have in your family history; ie. parents, siblings, aunts & uncles)

YES NO

- Prostate cancer
 Kidney, Bladder or other urological cancers
 Kidney stones
 Diabetes, Hypertension, Heart attack, Stroke,
 Other cancers

If YES explain below

PERSONAL HISTORY: (You only)

YES NO

- Smoking:
 Alcohol:
 Recreational drugs:

If YES explain below

_____ packs/day, for _____ years
 Socially Frequently

REVIEW OF SYSTEMS (Check if you have any of the following):

YES NO

- Ears and Hearing:** Loss of hearing, Buzzing, Infections
 Nose and Throat: Hoarseness, Difficulty swallowing,
Nose bleed, Frequent sneezing
 Respiratory: Shortness of breath, Wheezing, Cough
 Cardiovascular: Chest pain, Abnormal heartbeats,
Swelling of ankle or feet, Varicose vein
 Gastrointestinal: Abdominal pain, Nausea-vomiting,
Loss of appetite, Diarrhea, Constipation, Blood in stool
 Genitourinary: Problem going to bathroom, Blood in
urine, Incontinence, Other urinary symptoms
 Skin: Itching skin, Rashes, Sores not healing
 Musculoskeletal: Joint pains or swelling, Difficulty walking,
Back or pains in the bones
 Neurological: Headaches, Dizziness, Seizures, Numbness
or tingling, Blackouts, Lapse of memory
 Psychological: Depression, Excessive stress, Hopelessness

If YES explain below

Reviewed by Dr.: _____