PRE-APPOINTMENT INFORMATION

Please fill out this form as thoroughly as possible and bring it with you to your appointment. **All questions must be answered**, if you are unsure of an answer, please put "don't know", if question doesn't apply, please put "N/A".

Last Name		First Name	
Date Of Birth		Today's Date	
Referring Doctor		Family Doctor	
Pharmacy Name & Location			

ALLERGIES

Medication		Reaction
Are you allergic to radiation contrast?	Y / N	

MEDICATIONS (Please bring medicines to your appointment) (Attach list if necessary)

Medication	Dosage	How many times a day?

PAST SURGICAL HISTORY

✓	Surgery	Date	✓	Surgery	Date	✓	Surgery	Date
	Appendix Removal			Eye Surgery			Rectal Surgery	
	Back Surgery			Heart Surgery			Shoulder Surgery	
	Bladder Suspension			Hernia Repair			Thyroid Surgery	
	Brain Surgery			Hip Replacement			Tonsillectomy	
	Cesarean Delivery			Hysterectomy			TURP	
	Gallbladder Removal			Knee Surgery			Vaginal Delivery	
	Colon Resection			Neck Surgery			Weight Loss Surgery	
Other:								

Age 51-75	Have you had a colonoscopy?	Y / N	When?
Age 65 +	Have you had the Pneumonia Vaccine?	Y / N	When?

PAST MEDICAL HISTORY

✓	Problem	✓	Problem	✓	Problem	✓	Problem
	Asthma		Diabetes Type I		Heart Failure		Osteoarthritis
	Atrial Fibrillation		Diabetes Type II		Hepatitis		Parkinson's Disease
	Breast Cancer		Glaucoma		HIV		Sleep Apnea
	Chest Pain		Heart Attack		Hypertension		Stroke
	Chronic Kidney Failure		Heart Disease (with chest pain)		Kidney Stones		Thyroid Disorder
	COPD		Heart Disease (no chest pain)		Multiple Sclerosis		Prostate Cancer
Other:							

FAMILY HISTORY

Problem	Family Member	Problem	Family Member	Problem	Family Member
Prostate Cancer		Diabetes		Kidney Stones	
Bladder Cancer		Heart Attack		Kidney Cancer	
Colon Cancer		Hypertension		Breast Cancer	
Other:					

SOCIAL HISTORY

Smoking Status:	Current Every Day User	Current Some Day User	Former Smoker	Never Smoked

Do you drink alcohol?	Yes	Not Anymore	Never	Do you use recreational Drugs?	Yes	No

REVIEW OF SYSTEMS

✓	General	✓	Cardiovascular	✓	ENT	✓	Respiratory
	fever/chills		leg swelling		bleeding gums		asthma
	fatigue/weakness		exercise intolerance		hearing loss		pneumonia
	weight gain		irregular heart beat		nose bleeds		shortness of breath
	weight loss		palpitations		dizziness		cough
✓	Eyes	✓	Integumentary	✓	GU (Male)	✓	Hematologic
	blurred vision		changing moles		blood in urine		easy bleeding/bruising
	double vision		hair loss		painful urination		swollen glands
	dry eyes		itching		urinary incontinence		anemia
	glasses/contacts		skin rash		erectile dysfunction		HIV
✓	Gastrointestinal	✓	Musculoskeletal	✓	GU (Female)	✓	Psych
	constipation		muscle cramps		blood in urine		anxiety
	diarrhea		joint pain		painful urination		depression
	nausea/vomiting		back pain		urinary incontinence		hallucinations
	rectal bleeding		neck pain/stiffness		vaginal discharge		difficulty sleeping

MEN ONLY

If you are being seen for prostate problems and related difficulty urinating, please complete the following:

Over the Past 1 Month:	Not at all	< 20% of the time	< 50% of the time	50% of the time	> 50% of the time	Almost always
How often have you had a sensation of not emptying your bladder completely?	0	1	2	3	4	5
How often did you urinate more than once within a 2-hour period?	0	1	2	3	4	5
How often have you stopped and started several times while urinating?	0	1	2	3	4	5
How often have you had difficulty postponing urination?	0	1	2	3	4	5
How often have you had a weak urinary stream?	0	1	2	3	4	5
How often did you strain to begin to urination?	0	1	2	3	4	5
How many times did you get up during the night to urinate?	0 Times	1 Time	2 Times	3 Times	4 Times	5 Times

Total Score: _____