This form <u>MUST</u> be completed and faxed <u>PRIOR</u> to your consultation appointment. Please fax to Dr. Catalona at <u>312-695-1144</u> as soon as possible.

NEW PATIENT CONSULTATION FORM FOR DR. WILLIAM CATALONA

LAST NAME: _____ FIRST NAME: _____ MI: ___ D.O.B. __ / __ / __

OCCUPATION: _____ REFERRING DOCTOR: _____

HEIGHT: __' __" WEIGHT: _____ LBS DO YOU HAVE ANY ALLERGIES? _____

IF YES, PLEASE LIST AND DESCRIBE REACTION: _____

<u>PSA HISTORY</u>

DATE:	**RESULT:**		**DATE:**	**RESULT:**
__ / __ / __	_____		__ / __ / __	_____
__ / __ / __	_____		__ / __ / __	_____
__ / __ / __	_____		__ / __ / __	_____
__ / __ / __	_____		__ / __ / __	_____

<u>RECENT BIOPSY HISTORY</u>

DATE: GLEASON SCORE:

__ / __ / __ ____ + ____ = ____ # OF POSITIVE CORES ____ OUT OF _____

<u>PAST BIOPSY HISTORY</u>

DATE:	**RESULT:**		**DATE:**	**RESULT:**
__ / __ / __	_____		__ / __ / __	_____
__ / __ / __	_____		__ / __ / __	_____

- WERE ANY ABNORMALITIES FELT DURING YOUR RECTAL EXAM? Yes No

IF YES, PLEASE DESCRIBE: _____

- WERE ANY ABNORMALITIES FOUND DURING YOUR ULTRASOUND? Yes No

IF YES, PLEASE DESCRIBE: _____

- HAVE YOU BEEN TREATED WITH RADIATION OR HORMONES? Yes No

IF YES, PLEASE DESCRIBE: _____

MEDICATION HISTORY

PLEASE LIST ALL MEDICATIONS BELOW (INCLUDING VITAMINS/SUPPLEMENTS, OVER-THE-COUNTER, AND MEDICATIONS TAKEN ONLY AS NEEDED):

MEDICATION:	DOSAGE:	FREQUENCY:

SURGICAL HISTORY

PLEASE LIST ALL PAST SURGERIES BELOW:

SURGERY:	YEAR:

FAMILY MEDICAL HISTORY

● DO YOU HAVE A FAMILY HISTORY OF CANCER? Yes No

(PLEASE DESCRIBE CANCER HISTORY BELOW. PLEASE INCLUDE ALL INCIDENCES OF CANCER IN BLOOD RELATIVES, INCLUDING **PARENTS, SIBLINGS, HALF-SIBLINGS, CHILDREN, GRANDPARENTS, GREAT-GRANDPARENTS, COUSINS, AUNTS/UNCLES, ETC**.)

RELATION	***YEAR OF DIAGNOSIS***	***AGE AT DIAGNOSIS***	***LIVING / DECEASED?***	***TYPE OF CANCER***	***PATERNAL OR MATERNAL?***

● DO YOU HAVE A FAMILY HISTORY OF OTHER DISEASES? Yes No

IF YES, PLEASE DESCRIBE IN DETAIL:

_____

_____

_____

● FATHER'S AGE: ____ IF DECEASED, AT WHAT AGE? ____ CAUSE OF DEATH _____

● MOTHER'S AGE: ____ IF DECEASED, AT WHAT AGE? ____ CAUSE OF DEATH _____

● HOW MANY SISTERS DO YOU HAVE? _____ HOW MANY BROTHERS DO YOU HAVE? _____

● DO ANY OF YOUR SIBLINGS HAVE A MAJOR ILLNESS? Yes No

● HAVE ANY OF THEM DIED FROM A MAJOR ILLNESS? Yes No

IF YES, WHAT IS THE ILLNESS? _____

SOCIAL HISTORY

- HAVE YOU EVER SMOKED OR USED TOBACCO ON A REGULAR BASIS? Yes No

IF YES, PLEASE LIST FORM OF TOBACCO, HOW MUCH, HOW OFTEN, AND WHEN LAST USED:

_____

- DO YOU DRINK ALCOHOL? Yes No

IF YES, HOW MANY DRINKS AND HOW OFTEN? _____

- DO YOU USE RECREATIONAL DRUGS? Yes No

IF YES, PLEASE LIST DRUG, HOW MUCH, HOW OFTEN, AND WHEN LAST USED:

_____

MARITAL STATUS: _____ NAME OF SPOUSE/ SIGNIFICANT OTHER: _____

NUMBER OF DAUGHTERS: _____ NUMBER OF SONS: _____

- PLEASE ESTIMATE YOUR ERECTIONS AT THIS TIME ON A SCALE OF 1-10
(5 BEING ADEQUATE FOR PENETRATION AND 10 BEING THE BEST):

WITHOUT ERECTILE AIDS _____ WITH ERECTILE AIDS (IF NECESSARY) _____

- DO YOU USE ERECTILE AIDS? Yes No

IF YES, PLEASE DESCRIBE: _____

HISTORY OF MEDICAL ILLNESSES

PLEASE LIST ANY MEDICAL ILLNESSES YOU MAY HAVE.

_____

_____

_____

_____

REVIEW OF SYSTEMS

PLEASE CHECK ANY OF THE FOLLOWING SYMPTOMS THAT ARE CURRENTLY BOTHERING YOU, OR HAVE BEEN A PROBLEM IN THE PAST:

HEAD/ EARS/ EYES/ NOSE/ THROAT/ MOUTH

☐ Headaches/ Migraines
☐ Loss of Vision
☐ Blurred Vision
☐ Decreased Hearing
☐ Ringing in Ears
☐ Frequent Ear Infections
☐ Dizziness
☐ Sinus Problems
☐ Difficulty Swallowing
☐ Sleep Apnea

CARDIOVASCULAR

☐ Heart Problems
☐ High Blood Pressure
☐ High Cholesterol Levels
☐ Heart Attack
☐ Chest Pain
☐ Irregular Rhythm

RESPIRATORY

☐ Chronic Cough
☐ Wheezing
☐ Cough up Blood
☐ Shortness of Breath
☐ Asthma
☐ Pneumonia
☐ Tuberculosis
☐ Frequent Bronchitis

GASTROINTESTINAL

☐ Frequent Indigestion
☐ Nausea
☐ Vomiting
☐ Diarrhea
☐ Constipation
☐ Blood in Stools
☐ Colitis
☐ Ulcers
☐ Hemorrhoids
☐ Hernias/Hernia Surgery

URINARY

☐ Frequency
☐ Urgency
☐ Hesitancy
☐ Incomplete Bladder Emptying
☐ Incontinence
☐ Nocturia (____ times per night)
☐ Blood in Urine
☐ Weak Size & Force of Stream

MUSCULOSKELETAL

☐ Arthritis/Joint Pain
☐ Back or Neck Problems
☐ Gout
☐ Sciatica
☐ Stiffness

SKIN

☐ Rashes
☐ Abnormal Lumps
☐ Abnormal Moles/Removal of
☐ Dermatitis

CENTRAL NERVOUS SYSTEM

☐ Loss of Consciousness
☐ Stroke
☐ Seizures/ Epilepsy
☐ Numbness
☐ Tingling
☐ Spinal Cord/ Head Injury

ENDOCRINE

☐ Thyroid Problems
☐ Diabetes

HEMATOLOGIC

☐ Bleeding
☐ Bruising
☐ Anemia

PSYCHIATRIC

☐ Moodiness
☐ Depression
☐ Tension/Anxiety
☐ Other _____

**** PLEASE PROVIDE CONTACT INFORMATION FOR ALL DOCTORS INVOLVED IN YOUR CARE AND WHOM YOU WOULD LIKE TO RECEIVE YOUR RECORDS.

_____

_____

_____

_____

_____