

This form MUST be completed and faxed PRIOR to your consultation appointment. Please fax to Dr. Catalona at 312-695-1144 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: _____

PSA HISTORY

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

RECENT BIOPSY HISTORY

DATE: _____ GLEASON SCORE: _____
 __ / __ / __ ___ + ___ = ___ # OF POSITIVE CORES ___ OUT OF ___

PAST BIOPSY HISTORY

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):

<u>MEDICATION:</u>	<u>DOSAGE:</u>	<u>FREQUENCY:</u>

SURGICAL HISTORY

PLEASE LIST ALL PAST SURGERIES BELOW:

<u>SURGERY:</u>	<u>YEAR:</u>

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? _____

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.
