

**This form MUST be completed and faxed PRIOR to your consultation appointment. Please fax to Dr. Catalona at 312-695-7030 as soon as possible.**

**NEW PATIENT CONSULTATION FORM FOR WILLIAM J. CATALONA MD**

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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.**)

<i><b>RELATION</b></i>	<i><b>YEAR OF DIAGNOSIS</b></i>	<i><b>AGE AT DIAGNOSIS</b></i>	<i><b>LIVING / DECEASED?</b></i>	<i><b>TYPE OF CANCER</b></i>	<i><b>PATERNAL OR MATERNAL?</b></i>

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

*IF YES, PLEASE DESCRIBE IN DETAIL:*

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• 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.

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