



Form with fields: First Name, MI, Last Name, Medical Record #

PREFERRED PHARMACY (Name/Address/Phone):

MY MAIN PROBLEMS: High PSA, Enlarged Prostate, Blood in urine, Bladder Infection, Kidney Stones, Prostate Infection, Urinary Incontinence, Bladder Cancer, Prostate Cancer, Erectile Dysfunction, Overactive Bladder, Infertility, Lump in Testicle, Other:

ALLERGIES: None, PCN, Sulfa, Cipro, Iodine/Contrast, Other:

MEDICATIONS:

SURGICAL HISTORY: No Changes, Appendectomy, Back/Hip/Knee, Cystoscopy, Kidney Stone Surgery, Heart Bypass, Gallbladder, Prostate Biopsy, Lithotripsy, Prostate Surgery, Prostate Seed, Other:

MEDICAL HISTORY: No Changes, Diabetes, Emphysema, Heart Attack, Heart Murmur, Hepatitis, Hernia, Hypertension, Parkinson's, Strokes, Cancer: (Kidney, Testes, Prostate, Other Cancer), Other:

FAMILY HISTORY: Prostate Cancer, Kidney Cancer, Kidney Stones, Heart Disease

SOCIAL HISTORY: Occupation, Retired, Marital Status: Single, Married, Divorced, Widowed, Smoke: No, Yes

MY SYMPTOM(S): General/Constitutional, Eyes, Ears, Nose, Mouth, Throat, Cardiovascular, Respiratory, Gastrointestinal, Genitourinary, Musculoskeletal, Integumentary/Skin, Neurologic, Hematologic/Lymphatic

URINARY SYMPTOM(S): Incomplete Emptying, Frequency, Intermittency, Weak stream, Straining, Testicle Pain, Pain in side: R / L, Urinating at night (#)

In compliance with California OHS A Title 8, Section 5199, healthcare facilities must prescreen patients for aerosol transmissible diseases. Please let the nurse know if you have any of the following:

- Yes No History or Symptoms of Tuberculosis (productive cough, bloody sputum, fever, malaise, night sweats, unexplained weight loss)
Yes No Flu & Other Aerosol transmissible diseases, including pertussis, measles, mumps, rubella, chicken pox, meningitis