Patient Name _____ Date _____

MEDICAL HISTORY

Please complete your past medical, social and family history.

If male, have you had PSA blood test? ___ Yes ___ No If yes, please list result and date _____

Please list any surgical procedures:

Type of surgery Year Hospital Surgeon

_____

_____

_____

_____

_____

Please list all medications and dosage:

Medicine Dosage Amount

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Please list allergies/reactions to medications:

Allergy Reaction

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Name and location of preferred pharmacy: _____

Is there a family history of:

Bedwetting ___ Yes ___ No Who? _____ Age at onset _____

Diabetes ___ Yes ___ No Who? _____ Age at onset _____

Kidney Stones ___ Yes ___ No Who? _____ Age at onset _____

Prostate Cancer ___ Yes ___ No Who? _____ Age at onset _____

Have you smoked tobacco products? ___ Yes ___ No Current User _____ Former User _____

How many years did, or have you smoked? _____

Do you use caffeine? ___ Yes ___ No If yes, how many cups per day? _____

Do you drink alcohol? ___ Yes ___ No If yes, describe use: _____ Mild _____ Moderate _____ Heavy

Travel Overseas? ___ Yes ___ No When _____ Where _____

Occupation _____

Retired? ___YES ___NO ____ SEMI

Are your parents living? ___YES ___NO

If not, age and cause of death: Mother: _____ Father: _____

Women ONLY Health Section:

Number of children ____

Are you on Birth Control? ___ Yes ___ No

Do you have painful Period? ___ Yes ___ No

Are you sexually active? ___ Yes ___ No

Number of Pregnancies ____

Do you have Irregular Periods? ___ Yes ___ No

Are you on Birth Control? ___ Yes ___ No