Please complete this information prior to your appointment with us.

Name		Date of Birth	

Medication Allergies	

Other Allergies	

Medications	Drug	Dose	How Taken

Vitamins & Supplements	

Do you have any of the following?

Unexplained Weight Loss	☐	Yes	☐	No
Chest Pain	☐	Yes	☐	No
Shortness of Breath	☐	Yes	☐	No
Leg/Ankle Swelling	☐	Yes	☐	No
Coughing up Blood	☐	Yes	☐	No
Blood in Bowel Movement	☐	Yes	☐	No
Numbness or Tingling	☐	Yes	☐	No
Rashes or Skin Problems	☐	Yes	☐	No
Current Allergic Reactions	☐	Yes	☐	No
Other Unusual Symptoms	☐	Yes	☐	No
Pacemaker	☐	Yes	☐	No
Defibrillator	☐	Yes	☐	No

Does your family have a history of the following?

Prostate Cancer	☐	Yes	☐	No
Kidney Disease	☐	Yes	☐	No
Kidney Stones	☐	Yes	☐	No
Bladder Problems	☐	Yes	☐	No

Do you currently use tobacco? ☐ Yes ☐ No

If yes,

What brand?	
How much?	
How long?	

Cadillac Urology Practice 2005