

Donald L. Lamm, MD, FACS
Bladder Cancer
Genitourinary Oncology

BCG Oncology, PC

16620 N 40th St., Suite E
Phoenix, AZ 85032
602-493-6626

**New Patient History
Hematuria**

Name: _____

DOB: _____

Referred by: _____

Phone: _____

Date of Onset: _____

Initial symptom/reason for visit:

Previous Surgery or Cystoscopy:

Previous Treatments:

Recent X-ray Studies:

Do you have: (Circle "N" for No and "Y" for Yes)

Visible blood in the urine?	N	Y	Do you have clots?	N	Y
Cramping back or abdominal pain?	N	Y	Intensity from 1 to 10? _____	Relieved by? _____	
Burning with urination?	N	Y	Intensity from 1 to 10? _____	Relieved by? _____	
Other related pain?	N	Y	Intensity from 1 to 10? _____	Relieved by? _____	
Frequency of urination?	N	Y	Every _____ hours or _____ times a day		
Urination at night?	N	Y	Number of times a night _____		
Decrease force of stream?	N	Y			
Leakage of urine?	N	Y	Pads? N Y	Number per day _____	
History of kidney stones?	N	Y	Dates _____	Side? L R	

Other related problems?

Exposure to Cancer Causing Agents (Carcinogens)

Tobacco:

Never Yes Quit Date: _____

Maximum number of cigarettes/ day: _____

Pipe: N Y Cigars: N Y Chew/Snuff: N Y

Family History of Cancer? Bladder, Kidney, or Prostate Disease?

Other related problems?

Past Medical History

Describe Your General Health:

Illnesses:

Asthma Diabetes Heart Disease
Kidney Disease Pneumonia TB
Other:

Allergies:

Medicines/Dose:

Immunizations:

Past Surgical History: (Please List Procedures and Dates)

Systems Review: (please circle if present)

Normal Weight:_____ Height:_____ Constitutional: fever chills
Eyes: Lenses Blurring Double Spots
Ears: Ringing Decreased Hearing
Nose/Throat: Sinuses Swallowing
Cardiovascular: Shortness of Breath Chest Pain Ankle Swelling Calf Pain Irregular Heart Beat
I can climb ___ flights of stairs without stopping.
Respiratory: Cough Blood in Sputum Wheezing
Gastrointestinal: Nausea Vomiting Constipation Diarrhea Blood in Stool Belly Pain Heartburn
Genitourinary: Discharge Bleeding Sexual Problems
Musculoskeletal: Pain or Stiffness in Bones or Joints Muscle Pain or Weakness
Psychiatric: Depression Memory Loss Personality Change
Neurologic: Numbness Tingling Shooting Pains Weakness Seizures Loss of Consciousness
Dermatologic: Rash Itching Growths/Changes in Moles
Endocrine: Heat or Cold Intolerance Increased Thirst Lack of Energy Slow Healing
Hematologic/Lymphatic: Increased Bruising Bleeding Node Swelling
Allergic/Immunologic: Rashes Allergies Itching; Hives
Family History of: Diabetes Heart Kidney, Bladder or Prostate Disease Bleeding Disorders Cancer

Family History:	Living/Age	Deceased/Age	Illnesses
Father			
Mother			
Brother(s)			
Sister(s)			
Children			

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Social History: (* optional)

Occupation: _____

*Marital Status: _____

*Activity: I exercise vigorously _____ times per week
I sleep about _____ hours in 24

*Diet: I eat _____ servings of vegetables or fruit per day.
I have red meat _____ times per week; fish _____ times per week
I have salad _____ times per week
I eat fast food __+_ and restaurant food _____ times per week.
My favorite food is: _____

Alcohol: N Y _____ drinks per week

Tobacco: N Y

*Hobbies: _____

*Recent Foreign Travel: _____

*Religious Preference: _____