

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
Prostate**

Name: _____

DOB: _____

Referred by: _____

Phone: _____

Date of Onset: _____

Initial symptom/reason for visit:

Previous PSA tests:

Value/Date: _____

Previous Prostate biopsy?

N Y

Date/Result: _____

Current Symptoms: (Circle "N" for No and "Y" for Yes)

Pain?

N Y

Location: _____

Intensity from 1 to 10? _____ Relieved by? _____

Shortness of breath?

N Y

Abdominal swelling or mass?

N Y

Appetite?(Please circle)

Normal

Decreased Increased

Weight loss or gain?

N Y

How many pounds? _____ in the past _____ months.

Energy?

Normal

Decreased Increased

Lumps or bumps anywhere?

N Y

Swelling of ankles?

N Y

Do you have:

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 _____

Erections?

N Y

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? _____

History of kidney stones?

N Y

Dates _____ Side? L R

Other related problems?

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Activity:

Fully active? N Y
Limited In bed? N Y Less than ½ the time N Y More than ½ the time N Y
Confined to bed? N Y

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

Previous Surgery or Cystoscopy/dates:

Previous Treatments:

Recent Xray Studies? _____ Date/Result: _____

Bone Scan? N Y Date/Results _____

CT? N Y Date/Results _____

MRI? N Y Date/Results _____

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			

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: _____