

Please fax completed form to Joy Harmon at 312-695-1144 as soon as possible

NEW PATIENT CONSULTATION FOR DR. WILLIAM CATALONA

DATE: __ / __ / __ LAST NAME: _____ FIRST NAME: _____ MI: _____

D.O.B. __ / __ / __ OCCUPATION: _____ REFERRING DOCTOR: _____

MARITAL STATUS: _____ NAME OF SPOUSE OR SIGNIFICANT OTHER: _____

NUMBER OF DAUGHTERS: _____ NUMBER OF SONS: _____

**** PLEASE PROVIDE CONTACT INFORMATION FOR ALL DOCTORS INVOLVED IN YOUR CARE AND WHOM YOU WOULD LIKE TO RECEIVE YOUR RECORDS.

SOCIAL HISTORY

● HAVE YOU EVER SMOKED OR USED TOBACCO ON A REGULAR BASIS? Yes No

IF YES, PLEASE LIST FORM OF TOBACCO, HOW MUCH, HOW OFTEN, AND WHEN LAST USED:

● DO YOU DRINK ALCOHOL? Yes No

IF YES, HOW MANY DRINKS AND HOW OFTEN? _____

● DO YOU USE RECREATIONAL DRUGS? Yes No

IF YES, PLEASE LIST DRUG, HOW MUCH, HOW OFTEN, AND WHEN LAST USED:

PROSTATE CANCER SCREENING HISTORY

PSA HISTORY:

DATE:	RESULT:		DATE:	RESULT:
__/__/__	_____		__/__/__	_____
__/__/__	_____		__/__/__	_____
__/__/__	_____		__/__/__	_____
__/__/__	_____		__/__/__	_____

RECENT BIOPSY HISTORY:

DATE: _____ GLEASON SCORE: _____
 __/__/__ ____ + ____ = ____ # OF POSITIVE CORES ____ OUT OF ____

PAST BIOPSY HISTORY:

DATE:	RESULT:		DATE:	RESULT:
__/__/__	_____		__/__/__	_____
__/__/__	_____		__/__/__	_____

• HAVE YOU BEEN TREATED WITH RADIATION OR HORMONES? Yes No

IF YES, PLEASE DESCRIBE: _____

• WERE ANY ABNORMALITIES FELT DURING YOUR RECTAL EXAM? Yes No

IF YES, PLEASE DESCRIBE: _____

• WERE ANY ABNORMALITIES FOUND DURING YOUR ULTRASOUND? Yes No

IF YES, PLEASE DESCRIBE: _____

• DO YOU USE ERECTILE AIDS? Yes No

IF YES, PLEASE DESCRIBE: _____

• PLEASE ESTIMATE YOUR ERECTIONS AT THIS TIME ON A SCALE OF 1-10
 (5 BEING ADEQUATE FOR PENETRATION AND 10 BEING THE BEST):

WITHOUT ERECTILE AIDS _____ WITH ERECTILE AIDS (IF NECESSARY) _____

MEDICAL HISTORY

- DO YOU HAVE A FAMILY HISTORY OF CANCER? Yes No

(PLEASE DESCRIBE CANCER HISTORY BELOW. PLEASE INCLUDE ALL INCIDENCES OF CANCER IN BLOOD RELATIVES, INCLUDING **PARENTS, SIBLINGS, HALF-SIBLINGS, CHILDREN, GRANDPARENTS, GREAT-GRANDPARENTS, COUSINS, AUNTS/UNCLES, ETC.**)

<i>RELATION</i>	<i>YEAR OF DIAGNOSIS</i>	<i>AGE AT DIAGNOSIS</i>	<i>LIVING / DECEASED?</i>	<i>TYPE OF CANCER</i>	<i>PATERNAL OR MATERNAL?</i>

- DO YOU HAVE A FAMILY HISTORY OF OTHER DISEASES? Yes No

IF YES, PLEASE DESCRIBE IN DETAIL:

• FATHER'S AGE: ____ IF DECEASED, AT WHAT AGE? ____ CAUSE OF DEATH _____

• MOTHER'S AGE: ____ IF DECEASED, AT WHAT AGE? ____ CAUSE OF DEATH _____

• HOW MANY SISTERS DO YOU HAVE? _____ HOW MANY BROTHERS DO YOU HAVE? _____

• DO ANY OF YOUR SIBLINGS HAVE A MAJOR ILLNESS? Yes No

• HAVE ANY OF THEM DIED FROM A MAJOR ILLNESS? Yes No

IF YES, WHAT IS THE ILLNESS? _____

REVIEW OF SYSTEMS

PLEASE CHECK ANY OF THE FOLLOWING SYMPTOMS THAT ARE CURRENTLY BOTHERING YOU, OR HAVE BEEN A PROBLEM IN THE PAST:

**HEAD/ EARS/ EYES/
NOSE/ THROAT/ MOUTH**

- Headaches
- Dizziness
- Migraines
- Earaches
- Ringing in Ears
- Decreased Hearing

- Double Vision
- Loss of Vision
- Blurred Vision
- Frequent Eye Infections

- Dental Problems

NECK

- Stiffness
- Pain
- Lumps
- Difficulty Swallowing

CHEST

- Chronic Cough
- Frequent Cough
- Cough up Blood
- Shortness of Breath
- History of Asthma
- Pneumonia
- Tuberculosis
- Frequent Bronchitis

ABDOMEN

- Frequent Indigestion
- Nausea
- Vomiting
- Diarrhea
- Constipation
- Any Change in Bowel Habits
- Blood in Stools
- Colitis
- Ulcers
- Burning
- Hemorrhoids
- Hernias/Hernia Surgery

GENITOURINARY

- Frequent Urination
- Urgency
- Hesitancy
- Intermittency
- Incomplete Bladder Emptying
- Incontinence
- Nocturia (____ times per night)
- Blood in Urine
- Weak Size & Force of Stream

LOWER EXTREMITIES

- Arthritis
- Back or Neck Problems
- Joint Disease
- Sciatica

SKIN

- Rashes
- Abnormal Lumps
- Abnormal Moles
- Dermatitis
- Other Skin Problems

CONSTITUTIONAL

- Fainting
- Loss of Consciousness
- Epilepsy
- Seizures
- Numbness
- Tingling
- Loss of Coordination

ENDOCRINE

- Any Thyroid Problems
- Diabetes

HEMATOLOGIC

- Bleeding
- Bruising
- Anemia

PSYCHIATRIC

- Moodiness
- Depression
- Tension/Anxiety
- Other _____