

This form MUST be completed and faxed PRIOR to your consultation appointment. Please fax to Sanjina Shrestha at 312-695-1144 as soon as possible.

NEW PATIENT CONSULTATION FORM FOR DR. WILLIAM CATALONA

LAST NAME: _____ FIRST NAME: _____ MI: ___ D.O.B. ___ / ___ / ___

OCCUPATION: _____ REFERRING DOCTOR: _____

HEIGHT: ___' ___" WEIGHT: _____ LBS DO YOU HAVE ANY ALLERGIES? _____

IF YES, PLEASE LIST AND DESCRIBE REACTION: _____

PSA HISTORY

| DATE: | RESULT: | DATE: | RESULT: |
|-------------|---------|-------------|---------|
| ___/___/___ | _____ | ___/___/___ | _____ |
| ___/___/___ | _____ | ___/___/___ | _____ |
| ___/___/___ | _____ | ___/___/___ | _____ |
| ___/___/___ | _____ | ___/___/___ | _____ |

RECENT BIOPSY HISTORY

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

PAST BIOPSY HISTORY

| DATE: | RESULT: | DATE: | RESULT: |
|-------------|---------|-------------|---------|
| ___/___/___ | _____ | ___/___/___ | _____ |
| ___/___/___ | _____ | ___/___/___ | _____ |

- 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: _____

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

IF YES, PLEASE DESCRIBE: _____

MEDICATION HISTORY

PLEASE LIST ALL MEDICATIONS BELOW (INCLUDING VITAMINS/SUPPLEMENTS, OVER-THE-COUNTER, AND MEDICATIONS TAKEN ONLY AS NEEDED):

| <u>MEDICATION:</u> | <u>DOSAGE:</u> | <u>FREQUENCY:</u> |
|--------------------|----------------|-------------------|
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SURGICAL HISTORY

PLEASE LIST ALL PAST SURGERIES BELOW:

| <u>SURGERY:</u> | <u>YEAR:</u> |
|-----------------|--------------|
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| | |

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/ Migraines
- Loss of Vision
- Blurred Vision
- Decreased Hearing
- Ringing in Ears
- Frequent Ear Infections
- Dizziness
- Sinus Problems
- Difficulty Swallowing
- Sleep Apnea

CARDIOVASCULAR

- Heart Problems
- High Blood Pressure
- High Cholesterol Levels
- Heart Attack
- Chest Pain
- Irregular Rhythm

RESPIRATORY

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

GASTROINTESTINAL

- Frequent Indigestion
- Nausea
- Vomiting
- Diarrhea
- Constipation
- Blood in Stools
- Colitis
- Ulcers
- Hemorrhoids
- Hernias/Hernia Surgery

URINARY

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

MUSCULOSKELETAL

- Arthritis/Joint Pain
- Back or Neck Problems
- Gout
- Sciatica
- Stiffness

SKIN

- Rashes
- Abnormal Lumps
- Abnormal Moles/Removal of
- Dermatitis

CENTRAL NERVOUS SYSTEM

- Loss of Consciousness
- Stroke
- Seizures/ Epilepsy
- Numbness
- Tingling
- Spinal Cord/ Head Injury

ENDOCRINE

- Thyroid Problems
- Diabetes

HEMATOLOGIC

- Bleeding
- Bruising
- Anemia

PSYCHIATRIC

- Moodiness
- Depression
- Tension/Anxiety
- Other _____

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