

# NEW JERSEY CENTER FOR PROSTATE CANCER & UROLOGY

**PLEASE ANSWER THE FOLLOWING HEALTH QUESTIONS**

DO YOU SMOKE? \_\_\_\_\_ HOW MUCH? \_\_\_\_\_ DO YOU DRINK? \_\_\_\_\_ HOW MUCH? \_\_\_\_\_  
 DO YOU TAKE: ASPIRIN? \_\_\_\_\_ HOW MUCH? \_\_\_\_\_ BLOOD THINNERS? \_\_\_\_\_ COUMADIN? \_\_\_\_\_ PLAVIX? \_\_\_\_\_  
 VITAMINS? \_\_\_\_\_ LIST NAMES: \_\_\_\_\_

| FAMILY HISTORY | AGE   | LIVING | DECEASED | ANY ILLNESS | STATE OF HEALTH |
|----------------|-------|--------|----------|-------------|-----------------|
| MOTHER:        | _____ | _____  | _____    | _____       | _____           |
| FATHER:        | _____ | _____  | _____    | _____       | _____           |
| BROTHER:       | _____ | _____  | _____    | _____       | _____           |
| SISTER:        | _____ | _____  | _____    | _____       | _____           |

**ANY ALLERGIES?** \_\_\_\_\_ PLEASE LIST: \_\_\_\_\_

PHARMACY NAME \_\_\_\_\_ PHARMACY PHONE # \_\_\_\_\_

|                   |            |                 |
|-------------------|------------|-----------------|
| MEDICATION: _____ | DOSE _____ | FREQUENCY _____ |
| MEDICATION: _____ | DOSE _____ | FREQUENCY _____ |
| MEDICATION: _____ | DOSE _____ | FREQUENCY _____ |
| MEDICATION: _____ | DOSE _____ | FREQUENCY _____ |
| MEDICATION: _____ | DOSE _____ | FREQUENCY _____ |

**REVIEW OF SYSTEMS**

DO YOU NOW OR HAVE YOU HAD ANY PROBLEMS RELATED TO THE FOLLOWING SYSTEMS? CIRCLE YES OR NO.

**Constitutional Symptoms**

|        |   |   |             |   |   |
|--------|---|---|-------------|---|---|
| Fever  | Y | N | Headache    | Y | N |
| Chills | Y | N | Other _____ |   |   |

**Eyes**

|                |   |   |               |   |   |
|----------------|---|---|---------------|---|---|
| Blurred Vision | Y | N | Double Vision | Y | N |
| Pain           | Y | N | Other _____   |   |   |

**Ear / Nose / Throat / Mouth**

|               |   |   |                |   |   |
|---------------|---|---|----------------|---|---|
| Ear Infection | Y | N | Sinus Problems | Y | N |
| Sore Throat   | Y | N | Other _____    |   |   |

**Respiratory**

|                |   |   |                     |   |   |
|----------------|---|---|---------------------|---|---|
| Wheezing       | Y | N | Shortness of Breath | Y | N |
| Frequent Cough | Y | N | Other _____         |   |   |

**Gastrointestinal**

|                   |   |   |                         |   |   |
|-------------------|---|---|-------------------------|---|---|
| Abdominal Pain    | Y | N | Indigestion / Heartburn | Y | N |
| Nausea / Vomiting | Y | N | Other _____             |   |   |

**Genitourinary**

|                   |   |   |                   |   |   |
|-------------------|---|---|-------------------|---|---|
| Urine Retention   | Y | N | Urinary Frequency | Y | N |
| Painful Urination | Y | N | Other _____       |   |   |

**Musculoskeletal**

|            |   |   |             |   |   |
|------------|---|---|-------------|---|---|
| Joint Pain | Y | N | Back Pain   | Y | N |
| Neck Pain  | Y | N | Other _____ |   |   |

**Integumentary**

|                    |   |   |             |   |   |
|--------------------|---|---|-------------|---|---|
| Skin Rash          | Y | N | Boils       | Y | N |
| Persistent Itching | Y | N | Other _____ |   |   |

**Neurological**

|              |   |   |                     |   |   |
|--------------|---|---|---------------------|---|---|
| Tremors      | Y | N | Numbness / Tingling | Y | N |
| Dizzy Spells | Y | N | Other _____         |   |   |

**Endocrine**

|                  |   |   |                  |   |   |
|------------------|---|---|------------------|---|---|
| Excessive thirst | Y | N | Tired / Sluggish | Y | N |
| Too Hot / Cold   | Y | N | Other _____      |   |   |

**Cardiovascular**

|                     |   |   |                |   |   |
|---------------------|---|---|----------------|---|---|
| Chest Pains         | Y | N | Varicose Veins | Y | N |
| High Blood Pressure | Y | N | Other _____    |   |   |

**Hematologic / Lymphatic**

|                |   |   |                        |   |   |
|----------------|---|---|------------------------|---|---|
| Swollen Glands | Y | N | Blood clotting problem | Y | N |
| Other _____    |   |   |                        |   |   |

**Allergic / Immunologic**

|             |   |   |                |   |   |
|-------------|---|---|----------------|---|---|
| Hay Fever   | Y | N | Drug Allergies | Y | N |
| Other _____ |   |   |                |   |   |

**Psychologic**

|   |   |   |
|---|---|---|
| Are you generally satisfied with your life? | Y | N |
| Do you feel severely depressed?             | Y | N |
| Have you considered suicide?                | Y | N |
| Other _____                                 |   |   |

Please explain any "Yes" answers here:

**PRIOR HISTORY**

|               | YES   | NO    |
|---------------|-------|-------|
| HEART TROUBLE | _____ | _____ |
| DIABETES      | _____ | _____ |
| ASTHMA        | _____ | _____ |
| GOUT          | _____ | _____ |
| CANCER        | _____ | _____ |

PLEASE EXPLAIN ANY "YES" ANSWERS HERE \_\_\_\_\_

**FEMALE / GYN**

HAVE YOU HAD OR DO YOU HAVE ANY OF THE FOLLOWING (CHECK EACH ITEM)

|                               |       |
|-------------------------------|-------|
| VAGINAL DISCHARGE             | _____ |
| IRREGULAR PERIODS             | _____ |
| PREGNANCIES                   | _____ |
| HOW MANY?                     | _____ |
| DATE OF LAST MENSTRUAL PERIOD | _____ |

**PHYSICIAN USE ONLY:**  
(COMMENTS / NOTES)

PHYSICIAN SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_