NORTH DALLAS UROLOGY ASSOCIATES

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NAME:_____ DATE:_____

Preferred Laboratory for blood work:_____

Pharmacy Name:_____ Location:_____ Phone:_____

LIST OF SURGERIES/ PAST MEDICAL HISTORY

1._____
2._____
3._____
4._____
5._____

PRESCRIPTIONS or OVER THE COUNTER:	MG (dosage)	TIMES A DAY?	# Per Day

ALLERGIES TO MEDICATION:

1._____ 3._____
2._____ 4._____

Have you ever smoked or used tobacco products? YES NO
_____Current Smoker (how many cigarettes per day do you smoke?) _____
Are you interested on quitting? YES NO
_____Former Smoker (when was last date you smoked?) _____

Do you drink alcohol now or in the past? YES NO
How often have you had 6 or more drinks on one occasion in the past year? (circle one)
Never Daily Weekly Monthy

Are you allergic to iodine or dye contrast? YES NO

Do you have prostate cancer in your family? YES NO

FAMILY HISTORY OF MEDICAL ILLNESS:

Father :_____ Paternal grandfather:_____
Mother :_____ Paternal grandmother:_____
Maternal grandfather:_____ Maternal grandmother:_____