6624 Fannin Street, Suite 2580
Houston, TX 77030
Phone: (844) MENS-MRI
Fax: (844) 308-5101
www.ProstateLaserCenter.com

PERSONAL INFORMATION:

Name: ____ **DOB:** ____________**Ht:**_______**Wt:**______

Address: ______________________________**City:** _______________ **State:** ____ **Zip Code:** __________

Telephone Number: ____________________________**Occupation:** _____________________________

Email: ____ **Insurance:** ______________________________

PSA: ____________________ **Referring MD:** ____

History of current illness: ____

____

Past Medical History: ____

Past Surgical History: _____________________/_____________________/_______________________

Type *Year* *Type* *Year* *Type* *Year*

FAMILY HISTORY: (*Family Member Who Has Had Any of the Following Conditions)*:

Cancer (Type): ______________________ **Heart Disease:** ___________________ **Bleeding Disorder:** _________________

ALLERGIES: ___________________________ _________________________ _________________________

Name of Medication/Reaction *Name of Medication/Reaction* *Name of Medication/Reaction*

SOCIAL HISTORY: (*please circle correct response)*

Tobacco use: Y or N ________________ **Alcohol use: Y or N** ________________ **Illicit drugs: Y or N** __________________

Packs per day? *Drinks per day?* *Type?*

Do you have any metallic foreign bodies or implants? Y or N ___________________________________

MEDICATIONS:

____ ____

Name of Medication/ Strength/How Many Times Per Day *Name of Medication/ Strength/How Many Times Per Day*

____ ____

Name of Medication/ Strength/How Many Times Per Day *Name of Medication/ Strength/How Many Times Per Day*

____ ____

Name of Medication/ Strength/How Many Times Per Day *Name of Medication/ Strength/How Many Times Per Day*

____ ____

Name of Medication/Strength/How Many Times Per Day *Name of Medication/ Strength/How Many Times Per Day*

____ ____

Name of Medication/Strength/How Many Times Per Day *Name of Medication/ Strength/How Many Times Per Day*

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REVIEW OF SYSTEMS: ***(please check all that apply)***

General-
- □ Weight loss or gain
- □ Fatigue
- □ Fever or chills
- □ Weakness

Skin-
- □ Rashes
- □ Lumps
- □ Itching
- □ Dryness

Head-
- □ Headache
- □ Head injury
- □ Neck Pain

Ears-
- □ Decreased hearing
- □ Ringing in ears
- □ Earache
- □ Drainage

Eyes-
- □ Vision Loss/Changes
- □ Glasses or contacts
- □ Pain
- □ Redness
- □ Blurry or double vision
- □ Glaucoma
- □ Cataracts

Nose-
- □ Stuffiness
- □ Discharge
- □ Itching
- □ Hay fever
- □ Nosebleeds

Throat-
- □ Bleeding
- □ Dentures
- □ Dry mouth

Neck-
- □ Swollen glands
- □ Pain
- □ Stiffness

Respiratory-
- □ Cough
- □ Sputum
- □ Coughing up blood
- □ Shortness of breath
- □ Wheezing
- □ Painful breathing

Cardiovascular-
- □ Chest pain or discomfort
- □ Tightness
- □ Palpitations
- □ Shortness of breath with activity
- □ Difficulty breathing lying down
- □ Swelling
- □ Sudden awakening from sleep with shortness of breath

Gastrointestinal-
- □ Swallowing difficulties
- □ Heartburn
- □ Nausea
- □ Change in bowel habits
- □ Rectal bleeding
- □ Constipation
- □ Diarrhea

Urinary-
- □ Frequency
- □ Urgency
- □ Burning or pain
- □ Blood in urine
- □ Incontinence
- □ Incomplete bladder emptying
- □ Weak stream
- □ Change in urinary stream
- □ Urinating at night

Musculoskeletal-
- □ Muscle or joint pain
- □ Stiffness
- □ Back pain

Neurologic-
- □ Dizziness
- □ Fainting
- □ Seizures
- □ Weakness
- □ Numbness

Hematologic-
- □ Easy bruising
- □ Easy or excessive bleeding

Endocrine-
- □ Heat or cold intolerance
- □ Sweating
- □ Frequent urination
- □ Thirst
- □ Change in appetite

Psychiatric-
- □ Nervousness
- □ Stress
- □ Depression
- □ Memory loss

For Nurses Use:

VS B/P________ HR _________ RR_________ T________ O2sat______