CONFIDENTIAL INFORMATION

ELLIOT B. LANDER, M.D., F.A.C.S.

DATE: _____

CONTACT INFORMATION

Name: _____

Date of Birth: _____ **Age:** _____ **Driver License:** _____

Address: _____

_____

Home Phone: _____

Cell: _____

Email: _____

Primary Care Physician: _____

Office Phone: _____

Address: _____

_____

PLEASE READ & SIGN THE FOLLOWING:

I directly assign all medical/surgical benefits to _____ and understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the doctor to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

SIGN HERE: **X** _____

_____

Last Name First Name Middle Initial

CHEIEF COMPLAINT: Please describe in ONE SENTENCE your main problem:

_____

_____

Please check any of the following you have:

☐ Heart Failure	☐ Heart Attack	☐ Stroke	☐ High Blood Pressure
☐ COPD/Emphysema	☐ Kidney Disease	☐ Ulcer Disease	☐ Hepatitis
☐ Diabetes	☐ Artificial Joints	☐ Kidney Stones	☐ High Cholesterol
☐ Artificial Heart Valves	☐ Incontinence	☐ Arthritis	☐ Other

OTHER MEDICAL PROBLEMS:

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

PREVIOUS SURGERIES	DATES
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

Have you seen a Urologist before? Yes No

If yes, reason: _____

Any Family History of Genetic Problems:_____

_____

_____

_____

_____

Last Name First Name Middle Initial

MEDICATIONS YOU TAKE ALLERGIES

1.	1.
2.	2.
3.	3.
4.	4.
5.	5.
6.	6.
7.	7.
8.	8.
9.	9.
10.	10.

SOCIAL HISTORY/HABITS:

Are you? ☐ Married ☐ Divorced ☐ Never married ☐ Single

Do you have children? ☐ Yes (how many?_____) ☐ No

I am: ☐ Currently working as a_____

☐ Retired from work as a_____

☐ Unemployed

Have you ever used tobacco? ☐ Yes ☐ No If yes, how much?_____

Do you currently smoke? ☐ Yes ☐ No If yes, how much?_____(packs per day)

Do you drink alcohol? ☐ Yes ☐ No How many drinks per day?_____

Have you ever had a transfusion? ☐ Yes ☐ No

Have you ever used recreational intravenous drugs? ☐ Yes ☐ No

Are you HIV+ or do you have AIDS? ☐ Yes ☐ No

Last Name First Name Middle Initial

HISTORY & REVIEW OF SYSTEMS

HAVE YOU EVER HAD OR DO YOU NOW HAVE ANY OF THE FOLLOWING? If yes, explain below:

Eyes:

Decreased vision	☐ Yes	☐ No
Blurred vision	☐ Yes	☐ No
Double vision	☐ Yes	☐ No

Pulmonary (Lung):

Shortness of Breath	☐ Yes	☐ No
Chronic Cough	☐ Yes	☐ No
Cough of Blood	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No

Gastrointestinal:

Weight loss	☐ Yes	☐ No
Decreased appetite	☐ Yes	☐ No
Change in bowels	☐ Yes	☐ No
Blood in stool	☐ Yes	☐ No
Gallbladder disease	☐ Yes	☐ No
Liver/Cirrhosis	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No
Ulcer	☐ Yes	☐ No

Endocrine:

Diabetes	☐ Yes	☐ No
Thyroid trouble	☐ Yes	☐ No
Goiter	☐ Yes	☐ No
Thyroid medication	☐ Yes	☐ No

Urinary Tract:

Kidney trouble	☐ Yes	☐ No
Kidney stone	☐ Yes	☐ No
Bloody urine	☐ Yes	☐ No
Frequent urination	☐ Yes	☐ No
Painful urination	☐ Yes	☐ No
Sugar/Albumin urine	☐ Yes	☐ No
Passing urine/night	☐ Yes	☐ No
Weak urine stream	☐ Yes	☐ No
Incontinence	☐ Yes	☐ No
Prostate disease	☐ Yes	☐ No
Frequent urine infection	☐ Yes	☐ No

Ears, Nose, Mouth & Throat:

Decreased hearing	☐ Yes	☐ No
Ringing in ears	☐ Yes	☐ No
Mouth pain or swelling	☐ Yes	☐ No

Cardiac (Heart):

Heart disease	☐ Yes	☐ No
High blood pressure	☐ Yes	☐ No
Chest pain or pressure	☐ Yes	☐ No
Heart murmurs	☐ Yes	☐ No
Heart palpitations	☐ Yes	☐ No

Muscular/Skeletal:

Back pain	☐ Yes	☐ No
Arthritis/Rheumatism	☐ Yes	☐ No
Muscle pain or weakness	☐ Yes	☐ No
Osteoporosis	☐ Yes	☐ No

Neurologic:

Headaches	☐ Yes	☐ No
Dizzy/Faint spells	☐ Yes	☐ No
Nervous disorders	☐ Yes	☐ No
Epilepsy/Seizures	☐ Yes	☐ No
Strokes	☐ Yes	☐ No

Psychiatric:

Mental illness	☐ Yes	☐ No
Depression	☐ Yes	☐ No
Nervous disorder	☐ Yes	☐ No

Reproductive System:

Venereal disease	☐ Yes	☐ No
HIV positive	☐ Yes	☐ No
Lumps in breast	☐ Yes	☐ No
Pain in breast	☐ Yes	☐ No
Nipple discharge	☐ Yes	☐ No
Sexual impotence	☐ Yes	☐ No

Allergies:

To dust	☐ Yes	☐ No
To plants	☐ Yes	☐ No
To animals	☐ Yes	☐ No

EXPLANATION:_____

_____

_____

_____