New Patient Information for Office of Dr. Stephen Lazarou

Your Name_____**Age**_____

Partner's Name_____**Age**_____

Who referred you?_____

Reason for your visit?_____

Please circle if you are experiencing any of the following <u>urinary</u> symptoms:

Frequency Urgency Burning Pain Blood Leakage Slow stream Incomplete emptying Discharge

Medications/Supplements/Vitamins:_____

_____

_____

Are you taking any blood thinners or aspirin?_____

Allergies:_____

Medical problems:_____

_____

Surgical procedures:_____

_____

Alcohol use:_____**/week** **Smoking**: _____

Job/Occupation:_____ **Drug use:**_____

Any **family** member with **prostate, bladder, testicular or kidney cancer**?_____

<u>Please circle if you experience any of the following</u>:

General changes: weight loss weight gain fever chills sweats **Skin:** rash itching lumps

Bleeding problems: bruise easily bleeding gums **Vision**: blurriness loss of vision

Neurological: headaches dizziness seizures **GI:** constipation diarrhea bloody stools pain

Mood changes: anxiety depression **Heart:** chest pain irregular beats fainting

Lungs: shortness of breath wheezing coughing **Smell:** congestion runny nose

Musculoskeletal: muscle weakness back pain flank pain