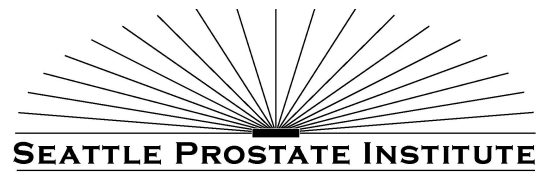


New Patient Questionnaire



Name _____ Today's date _____

MEDICAL HISTORY

Previous cancer	Y / N	Stroke	Y / N	Crohn's disease or Ulcerative colitis	Y / N
High blood pressure	Y / N	Emphysema/COPD	Y / N	Kidney loss, dysfunction or abnormality	Y / N
Heart attack	Y / N	Diabetes	Y / N	Lupus/Scleroderma/Collagen vascular disease	Y / N
Pacemaker	Y / N	Diverticulitis	Y / N	Rheumatoid/Psoriatic Arthritis	Y / N

Previous radiation therapy Y / N If yes, to what part of the body? _____

Facility name _____ Dates _____

Previous surgeries:

Type of Operation	Approximate Date	Type of Operation	Approximate Date
_____	_____	_____	_____
_____	_____	_____	_____

Other illnesses/hospitalizations _____

Prostate Surgery (Transurethral resection of prostate "TURP") Y/N If yes, when? _____

Prostate Biopsy Y/N If yes, when? _____ Date of last colonoscopy _____

MEDICATIONS/SUPPLEMENTS (List **ALL** medications/vitamins & supplements you are currently taking)

Medication	Dose	Dose/day	Medication	Dose	Dose/day
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

MEDICATION ALLERGIES _____ None

Medication _____ Reaction _____

Medication _____ Reaction _____

FAMILY HISTORY OF CANCER

Type/location of cancer	Age at diagnosis	Type/location of cancer	Age at diagnosis
Father _____	_____	Brother/sister _____	_____
Mother _____	_____	Brother/sister _____	_____

SOCIAL HISTORY

Do you drink alcohol Y / N If yes, average number of drinks per day _____

Have you ever smoked cigarettes Y / N If yes, year you began smoking _____ Year stopped _____

Average # of packs smoked per day _____ List other tobacco products used _____

Current occupation _____ # years _____

Previous occupation _____ # years _____

REVIEW OF SYSTEMS Have you developed any of these symptoms in the past year?

Weight loss	Y / N	Fatigue	Y / N	Cough	Y / N	Weakness	Y / N
Decreased appetite	Y / N	Fever	Y / N	Short of breath	Y / N	Numbness/Tingling	Y / N
Nausea	Y / N	Bone pain	Y / N	Chest pain	Y / N	Memory problems	Y / N
Diarrhea	Y / N	Skin rashes	Y / N	Depression	Y / N	Vision/Hearing changes	Y / N
Bleeding problems	Y / N	Swollen glands	Y / N	Headaches	Y / N	Change in urination	Y / N

I attest that all statements on this form are true and correct x _____