Donald L. Lamm, MD, FACS
Bladder Cancer
Genitourinary Oncology

BCG Oncology, PC

16620 N 40th St., Suite E
Phoenix, AZ 85032
602-493-6626

New Patient History
Kidney

Name:________________________ **DOB:**__________________ **Referred by:** ___________________

Phone:_______________________ **Date of Onset:**__________________

Initial symptom/reason for visit:

Current Symptoms: **(Circle "N" for No and"Y" for Yes)**

Pain?	N	Y	Location:______________ Intensity from 1 to 10?____ Relieved by?_________
Shortness of breath?	N	Y	
Abdominal swelling or mass?	N	Y	
Appetite?(Please circle)	Normal		Decreased Increased
Weight loss or gain?	N	Y	How many pounds?_____in the past_____ months.
Energy?	Normal		Decreased Increased
Lumps or bumps anywhere?	N	Y	
Swelling of ankles?	N	Y	

Do you have:

Visible blood in the urine?	N	Y	Do you have clots? N Y
Cramping back or abdominal pain?	N	Y	Intensity from 1 to 10?____ Relieved by?_________
Burning with urination?	N	Y	Intensity from1 to 10?____ Relieved by?_________
Other related pain?	N	Y	Intensity from 1 to 10?____ Relieved by?_________
Frequency of urination?	N	Y	Every_____ hours or _____ times a day
Urination at night?	N	Y	Number of times a night_____
Decrease force of stream?	N	Y	
Leakage of urine?	N	Y	Pads? N Y Number per day____
History of kidney stones?	N	Y	Dates__________________ Side? L R

Other related problems?

Previous Surgery or Cystoscopy/dates:

Previous Treatments:

Recent Xray Studies?________________________ Date/Result:____________________________________

Bone Scan? N Y Date/Results____

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CT? N Y Date/Results____

MRI? N Y Date/Results____

Activity:
Fully active? N Y
Limited In bed? N Y Less than ½ the time N Y More than ½ the time N Y
Confined to bed? N Y

Exposure to Cancer Causing Agents (Carcinogens)
Tobacco:
Never Yes Quit Date:_________

Maximum number of cigarettes/ day:___________

Pipe: N Y Cigars: N Y Chew/Snuff: N Y

Family History of Cancer? Bladder, Kidney, or Prostate Disease?

Other related problems?

Past Medical History

Describe Your General Health:

Illnesses:

Asthma	Diabetes	Heart Disease
Kidney Disease	Pneumonia	TB
Other:		

Allergies:

Medicines/Dose:

Immunizations:

Past Surgical History: (Please List Procedures and Dates)

Systems Review: (please circle if present)

Normal Weight:__________ Height:__________ Constitutional: fever chills
Eyes: Lenses Blurring Double Spots
Ears: Ringing Decreased Hearing
Nose/Throat: Sinuses Swallowing
Cardiovascular: Shortness of Breath Chest Pain Ankle Swelling Calf Pain Irregular Heart Beat
I can climb____ flights of stairs without stopping.
Respiratory: Cough Blood in Sputum Wheezing
Gastrointestinal: Nausea Vomiting Constipation Diarrhea Blood in Stool Belly Pain Heartburn
Genitourinary: Discharge Bleeding Sexual Problems
Musculoskeletal: Pain or Stiffness in Bones or Joints Muscle Pain or Weakness
Psychiatric: Depression Memory Loss Personality Change

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Systems Review: (please circle if present)

Neurologic: Numbness Tingling Shooting Pains Weakness Seizures Loss of Consciousness

Dermatologic: Rash Itching Growths/Changes in Moles

Endocrine: Heat or Cold Intolerance Increased Thirst Lack of Energy Slow Healing

Hematologic/Lymphatic: Increased Bruising Bleeding Node Swelling

Allergic/Immunologic: Rashes Allergies Itching; Hives

Family History of: Diabetes Heart Kidney, Bladder or Prostate Disease Bleeding Disorders Cancer

Family History:	Living/Age	Deceased/Age	Illnesses
Father			
Mother			
Brother(s)			
Sister(s)			
Children			

Social History: *(* optional)*

Occupation:_____________________________

*Marital Status:____________________________

*Activity: I exercise vigorously _____ times per week

I sleep about _____ hours in 24

*Diet: I eat ____ servings of vegetables or fruit per day.

I have red meat ____ times per week; fish ____ times per week

I have salad ____ times per week

I eat fast food __+_ and restaurant food ____ times per week.

My favorite food is:_____________________

Alcohol: N Y _____drinks per week

Tobacco: N Y

*Hobbies:____

*Recent Foreign Travel:____

*Religious Preference:____