Jim C. Hu, M.D.

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(Please Fill out this form with ink. It will become part of your medical record)

Name:_____ Date:_____

Age_____ Who referred you?_____

Reason for your visit: Prostate Cancer newly diagnosed previously treated

Other:_____

Last PSA_____ date_____. Last Prostate Biopsy date_____

Medical History: (please check off past or current medical problems)

Anemia	Asthma	Anxiety/Depression	Bleeding Disorder
Prostate Cancer	Bladder Cancer	Other Cancer	Diabetes
Gall Stones	Heart Murmur	Other Heart Disease	Hemorrhoids
High Blood Pressure	Hernia	Incontinence	Irritable Bowel
Kidney Disease	Migraines	Seizure Disorder	Thyroid Disease
Blood Clots	Sexual Problems	Stroke	Other

Childhood diseases: List any childhood diseases which may have a bearing on your present health i.e. mumps/infertility, rheumatic fever/heart disease, etc.

Surgical History:

Name of Procedure	Date of Procedure	Reason for Procedure

Current Medications:

Medications	Dose	# of times taken daily

Are you allergic to any medications? Yes, No

If Yes, please list medication and reaction:

Family History: Please answer Yes or No and list the family member that has the history.

Yes or No		Disease	Family Member (who i.e.: mother, father etc.)
Yes	No	Prostate Cancer	
Yes	No	Bladder Cancer	
Yes	No	Colon Cancer	
Yes	No	TB	
Yes	No	Thyroid	
Yes	No	Diabetes	
Yes	No	Kidney Disease	
Yes	No	High Blood Pressure	
Yes	No	Heart Disease	
Yes	No	Birth Defects	
Yes	No	Cystic Fibrosis	
Yes	No	Hormone Problems	
Yes	No	Fertility Problems	
Yes	No	Other	
Yes	No	No Significant History	

Social History:

Occupation:_____ Marital Status_____

Children: Yes, No How Many_____ Ages_____

Sexual Preference Men_____ Women_____ Both_____

Diet: Salt_____ Special _____ Vegetarian_____

Regular Exercise Routine? Yes/No If yes, please describe_____

Smoking: (List # of packs per day and years)_____

Alcohol: (List how many drinks per week)_____

Caffeine: (# of cups per day)_____

Marijuana or other drugs:_____

Past, Family or Social History Rules: Pertinent= 1 element from any category. Comprehensive= 1 specific item from each type or 1 specific item from 2 of 3 history types. 0 elements= 99203 3 elements= 99204 o 99205

Review of Systems:

Constitutional:		
Significant change in weight	Yes	No
Fever and Chills	Yes	No
Fatigue or Malaise	Yes	No
Heent:		
Persistent Headaches	Yes	No
Visual Problems	Yes	No
Ringing in your ears	Yes	No
Cardiovascular:		
Shortness of breath	Yes	No
Chest Pains	Yes	No
Palpitations	Yes	No

Respiratory:		
Cough	Yes	No
Wheezing	Yes	No
Gastrointestinal:		
Nausea and Vomiting	Yes	No
Diarrhea or Constipation	Yes	No
Other	Yes	No
Genito-urinary:		
Burning or discomfort on urination	Yes	No
Blood in urine	Yes	No
Incontinence of Urine	Yes	No
Musculoskeletal:		
Muscle weakness or other symptoms	Yes	No
Skin:		
Skin or rash lesions	Yes	No
Neurological:		
Loss of consciousness	Yes	No
Seizures	Yes	No
Numbness or Tingling	Yes	No
Psychiatric:		
Depression	Yes	No
Anxiety	Yes	No
Other:	Yes	No
Hematologic/lymp		
Easy bruising	Yes	No
Unusual bleeding	Yes	No
Allergy/Immunology:		
Allergies	Yes	No

0 symptoms= 99201 1 symptom= 99202 2-9 symptoms= 99203 10 or more symptoms= 99204 or 99205

Please list any additional information that you feel is relevant for your medical records:

Physician Notes:

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