Fred Khonsari, M.D.
1140 W. La Veta, Suite 605
Orange, CA 92868

Date: _____

Name:_____ Age:_____ Ht:_____Wt:_____
Last First Middle

Main Complaint:_____ Referring Physician:_____

History of Main Complaint (check "yes" or "no" where applicable):

1. Do you have:	YES	NO		YES	NO
• blood in your urine?			3. Do you need to get to the toilet quickly when you need to urinate?		
• burning when you urinate?					
• discharge?			4. Do you leak urine or wet underwear?		
2. How often do you urinate?			• when sneezing, coughing, laughing, or when exercising?		
• Urinate during the day (# times)					
• Wake up at night to urinate (# times)			• anytime?		

Urological History (check "yes" or "no" where applicable):

5. Have you had:	YES	NO	6. Do you have any sexual problems?		
• previous urological treatment or tests? (i.e. cysto)			7. (men only) Are you able to get an Erection?		
• kidney stones?			8. (women only) Is there a chance you are pregnant?		
• urinary tract infections?					
• kidney / bladder injuries?			Comment:		
• sexually transmitted diseases?					

List all medical illnesses and surgery you have had:

Past Illnesses:	Year	Past Surgery:	Year

List all known allergies to medicine and food:

Name of Allergy	Type of Reaction
1.	
2.	
3.	
4.	

Are you allergic to Iodine? - yes / no

Are you allergic to contrast dye? - yes / no

List ALL prescription, nonprescription, and herbal medications you are currently taking.

Name of Medication	Strength	Amount	Frequency	How Long?
1.				
2				
3.				
4.				
5.				
6.				
7.				

Family History:

Name	Age	Cause of Death, if deceased or list serious illnesses
Father		
Mother		
Spouse (if married)		
Children (list)		
1.		
2.		
3.		
4.		

Is there a family history of prostate cancer? Y/N If so, relationship:

Personal History:

Occupation:_____ Birthdate:_____/_____/_____ Marital Status: M S W D Sep

Do you smoke? Y / N How long?_____ How many per day?_____ Past smoker? Y / N Quit date: _____/_____/_____

Do you drink alcohol? Y / N Type?_____ How long?_____ How many per week?_____

Social drinker? Y / N Quit date: _____/_____/_____

Y	N	Constitutional	Y	N	Endocrine	Y	N	Psychiatric
__	__	Fatigue	__	__	Diabetes	__	__	Anxiety
__	__	Fevers	__	__	Thyroid disease	__	__	Depression
__	__	Loss of appetite	__	__	Weight loss	__	__	Moodiness
Y	N	Eyes	Y	N	Musculoskeletal	Y	N	Neurological
__	__	Eye pain	__	__	Back pain	__	__	Paralysis
__	__	Loss or blurring of vision	__	__	Neck pain	__	__	Numbness
__	__	Glaucoma	__	__	Joint pain or swelling	__	__	History of stroke
						__	__	Seizures
Y	N	Cardiovascular	Y	N	Gastrointestinal	Y	N	Hematologic
__	__	Chest pain	__	__	Nausea or vomiting	__	__	Bleeding disorder
__	__	Shortness of breath with exertion	__	__	Diarrhea	__	__	Easy bruising
__	__	Palpitations or irregular heart beat	__	__	Constipation	__	__	Use of Aspirin, Coumadin,
__	__	High blood pressure	__	__	Abdominal pain			Other blood thinners
__	__	Heart Attack	__	__	Jaundice or Hepatitis	__	__	Past blood transfusions

Y	N	Respiratory
__	__	Cough
__	__	Asthma
__	__	Sputum
__	__	Coughing blood

➔ All "yes" responses to the above questions need to be thoroughly discussed with your primary care physician. A copy of this list is available upon request.

➔ Information from this form may be used, with complete confidentiality, for urologic research.

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I have made in the completion of this form.

Patient Signature: _____ Date: _____/_____/_____

Physician Use Only

Physician Signature: _____ Date: _____/_____/_____

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PATIENT INFORMATION

TODAY'S DATE_____

PATIENT'S NAME_____
Last First Middle

AGE_____SEX_____ MARITAL STATUS (circle one) Married Single Divorced Widower/ed

SOCIAL SECURITY.#_____-_____-_____

BIRTH DATE_____/_____/_____ DRIVER'S LIC #_ (State)_____(Number)_____

ADDRESS_____ CITY_____STATE_____ZIP_____

HOME PHONE ( )_____ CELL PHONE ( )_____

PATIENT'S EMPLOYER_____OCCUPATION_____

WORK PHONE ( )_____SPOUSE'S WORK PHONE( )_____

SPOUSE'S NAME_____EMPLOYER_____

IF CHILD, STATE FATHER'S NAME_____EMPLOYER_____

IF CHILD, STATE MOTHER'S NAME_____EMPLOYER_____

NEAREST RELATIVE OR FRIEND_____ADDRESS_____

RELATION_____PHONE # ( )_____

INSURANCE COMPANY_____

INSURANCE POLICY / MEMBER # _____

INSURANCE AGREEMENT

I HEREBY AUTHORIZE FRED KHONSARI, M.D. TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENTS AND ALSO ASSIGN TO DR. FRED KHONSARI ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MY SELF OR MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.

PATIENT SIGNATURE_____DATE_____/_____/_____