Florida Urology Partners, LLP

Frank D. Mastandrea, M.D.

Name: _____ _____ _____ Today's Date: _____
Last First Middle

Date of Birth: _____

Reason for today's visit (Describe your problem in detail)

_____

_____

_____

Present Illness/ Current Problem: (Please circle all that apply)

Prostate Cancer

Renal Cancer

Elevated PSA

Benign Prostatic Hypertrophy

Erectile Dysfunction

Renal Stones

Urinary Incontinence

Urinary Tract Infection

Other _____

Past Medical History: (Please circle all that apply)

Hypertension/High Blood Pressure

Cholesterol

Coronary Artery Disease

Peripheral Vascular Disease

Diabetes Type 1 or Type 2

Cancer (type) _____

Type of Treatment_ _____

When _____

Other _____

Surgical History (Please circle all that apply)

Colon

Cardiac Surgery _____ (Type)

Hernia

TURP

Vasectomy

Tonsils/Adenoids

Cancer Surgery _____ (Type)

Other Surgery _____

Family History **Relation**

Renal Stones yes__ no__ _____

Kidney Disease yes__ no__ _____

Prostate Cancer yes__ no__ _____

Heart Disease yes__ no__ _____

High Blood Pressure

yes__ no__ _____

Diabetes yes__ no__ _____

Cancer (type) _____ _____

Social History (Please circle all that apply)

Single Married Separated Divorced Widowed

Number of Children _____

Occupation (Please circle all that apply)

Unemployed Home maker Student Retired Disabled

Employed (Position) _____

Tobacco

Do you smoke? yes ___ no ___

If yes, which cigarettes ___, cigars ___, pipe ___

How much daily? _____ Number of years ____

Have you ever smoked? yes ___ no ___

If yes, when did you stop? _____

Alcohol

Do you regularly drink alcohol? yes ___ no ____

Diet

Are you on a special diet? yes ___ no_____

If yes, type: _____

Medications: mg. Frequency

Allergies:

Urology Procedure History

Date

Referring Doctor:

Phone:

Other Doctors:

Phone:

Phone:

Phone: