Lazarou Urology Associates

Date _____ Name _____
Date of Birth_____Name of partner_____
Address:_____
Home Phone # _____Work Phone# _____Cell #_____
Email Address: _____
Can a confidential message be left on the above phone numbers/email address?Yes or No
Name of Referring Doctor or Therapist:_____
Name of Primary Care Doctor if different from referring:_____
Primary Care Physician's telephone number:_____
Occupation _____

Reason for seeing Dr. Lazarou (please circle, or list other problem):
Infertility Erectile/Sexual Dysfunction Difficulties with Urination
Prostate Issue Vasectomy/Vasectomy Reversal Other:_____

List Medications (including herbals/vitamins)		List any and all surgeries and at what age? (vasectomy, varicocele surgery, hernia, etc)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Which medications/substances (including Latex) are you allergic to and type of reaction?
_____

Have you had any of the following ? (please circle) If yes, when?

Heart Disease/Heart Attack	Y/N	Heat/Chemical Exposure	Y/N
High Blood Pressure	Y/N	Radiation/Chemotherapy	Y/N
Diabetes	Y/N	Kidney Stones	Y/N
High Cholesterol	Y/N	Blood in Urine	Y/N
Bleeding Problems	Y/N	Low Testosterone	Y/N
Testicular Cancer	Y/N	Mumps after Puberty	Y/N
Sexually Transmitted Disease	Y/N	Undescended Testicle	Y/N
Urinary Tract Infections	Y/N	Prostate Cancer	Y/N
Epididymitis	Y/N	Sleep Apnea	Y/N
Prostatitis	Y/N	Other problems?_____	

Any family history of prostate cancer? Y/N If yes, whom?_____
Do you have any children?____ Ages/Gender?_____
Any Family History of Infertility?_____
How much do you smoke? _____ How much alcohol do you drink?_____
Do you use any recreational drugs? Y/N If yes, which?_____