Desert Endovascular Center

Prostate Embolization – New Patient Intake Form

Patient Information

Patient Name: _____
Preferred Name: _____

Preferred Contact Method: ☐ Phone ☐ Email
Best Contact Phone Number: _____
Email Address: _____

Optional – Continuation of Care

If you would like us to share notes from today's visit, please provide the names of your medical care providers:

- **Primary Care Physician:** _____
- **Other Physicians (e.g., Urologist, Cardiologist, Oncologist, etc.):** _____

Reason for Visit

What brings you to see the doctor today?

Do you have other health problems (e.g., diabetes, hypertension, heart disease, etc.)?

Medical & Surgical History

Prior Surgery (Type & Date):

Current Medications (Dose & Frequency):

Allergies to Medications:

Allergic to Latex? ☐ Yes ☐ No

Do you have cancer? ☐ Yes ☐ No

Do you have high blood pressure, chest pain, heart disease, or history of heart attack? ☐ Yes ☐ No

Do you have diabetes? ☐ Yes ☐ No

Do you have hepatitis or liver disease? ☐ Yes ☐ No

Do you have kidney disease or kidney failure? ☐ Yes ☐ No

Do you have asthma, emphysema, or shortness of breath? ☐ Yes ☐ No

Do you have depression or other psychiatric conditions? ☐ Yes ☐ No

Do you have arthritis, joint pain, numbness, or tingling? ☐ Yes ☐ No

Do you have lupus or other autoimmune disease? ☐ Yes ☐ No

Urological History

- **Do you have urinary symptoms (e.g., frequency, urgency, weak stream, nocturia)?** ☐ Yes ☐ No
    - **If yes, please describe:** _____
- **Do you have a history of prostate problems or prior treatments (e.g., TURP, medications)?** ☐ Yes ☐ No
    - **If yes, please describe:** _____
- **Date of last PSA test (if known):** _____

Social History

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Did you bring anyone with you today? If so, who?

Do you smoke? ☐ Yes ☐ No

- **If yes, how much per day?** _____
- **Previously smoked?** ☐ Yes ☐ No
    - **If yes, when did you quit?** _____

Do you consume alcohol? ☐ Yes ☐ No

- **If yes, how much per week? _____**

Family history of prostate problems or prostate cancer? ☐ Yes ☐ No

- **If yes, who? _____**