



ALLIED UROLOGICAL SERVICES, LLC

Metropolitan Lithotripter Associates, PC

BPH Patient Information

Patient's Name _____ Date of Birth _____

Address _____ City/State/Zip _____

Age _____ Sex _____ Marital Status _____ Occupation _____

Height _____ Weight _____ Phone No. _____

Referring Physician Name: _____

1. Allergies: (Food, Drugs, Other) _____ Latex Allergy
2. Do you have an implanted active pacemaker or defibrillator? _____ Yes _____ No
3. Have you had a penile or sphincter implant? _____ Yes _____ No
4. Do you have any metallic implants in the pelvic area? _____ Yes _____ No
5. Do you have a ureteral stricture? _____ Yes _____ No
6. Do you have peripheral arterial disease with intermittent claudication? ___ Yes ___ No
7. Do you have a history of Leriche's syndrome or Prostate or bladder cancer? ___ Yes ___ No

List the person (s) to whom you authorize disclosure of your medical information. Please include the person who escorted you today.

Primary contact: _____ Relationship: _____

Address: _____ Phone number: _____

Secondary contact: _____ Relationship: _____

Address: _____ Phone number: _____

Patient Signature: _____ Date: _____