



**METROPOLITAN LITHOTRIPTOR ASSOCIATES, PC**  
*Allied Urological Services, LLC*

**Lithotripsy Patient Information**

Patient's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Age \_\_\_\_\_ Sex \_\_\_\_\_ Marital Status \_\_\_\_\_ Occupation \_\_\_\_\_

Phone No. \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Referring Physician: \_\_\_\_\_

1. Allergies: (Food, Drugs, Other) \_\_\_\_\_  Latex Allergy

2. Is this your first stone? \_\_\_\_\_

3. Is your stone(s) on the right, left, or both sides? \_\_\_\_\_

4. How long have you known about the stone? \_\_\_\_\_

5. How many episodes of stone-related pain have you had in the past 3 months? \_\_\_\_\_

6. Any previous kidney injury? \_\_\_\_\_

7. Any previous kidney infection? \_\_\_\_\_

8. Any previous urinary tract infection (UTI), bladder infection, or prostate infection? \_\_\_\_\_

9. If you have had previous stones:

a. How many passed on their own? Right \_\_\_\_\_ Left \_\_\_\_\_ Unknown Side \_\_\_\_\_

b. How many treated with ESWL (extracorporeal shock wave lithotripsy)? \_\_\_\_\_

c. How many pulled out from below with a basket? Rt. Side \_\_\_ Lt. Side \_\_\_ Not sure \_\_\_

d. How many required incision to remove?

Right side \_\_\_\_\_ Left side \_\_\_\_\_ Hospital and Year \_\_\_\_\_

10. Has a kidney or part of one ever been removed? \_\_\_\_\_

11. Any other operations on kidney or bladder? \_\_\_\_\_

12. Any prostate surgery? \_\_\_\_\_

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: \_\_\_\_\_