AUO
ALBANY UROLOGIC ONCOLOGY

Preparation for Your Visit to Albany Urologic Oncology

We want your visit to Albany Urologic Oncology to be a positive experience. Your visit with us starts before you even see us. Please have your referring physician send any records that may help us with your evaluation. The checklist that follows should help you with this:

- ○ Most recent blood work including a CBC (complete blood count) and CMP (comprehensive metabolic profile)
- ○ Most recent XRAY reports including ULTRASOUND, CT SCAN and MRI

We would ask that you please bring the following information to your visit:

- ○ A list of your ALLERGIES
- ○ A list of your CURRENT MEDICATIONS
- ○ A list of all of your physicians including NAME, PHONE NUMBER, ADDRESS and FAX
- ○ A list of your Medical History
- ○ A list of your Surgical History

WITH REGARD TO IMAGING: Many of our patients have complex disorders that require our careful interpretation of XRAY STUDIES. We want to see the actual study, not just the printed paper report. After all, you want our expert opinion. So we ask that you BRING YOUR STUDY TO US ON A COMPUTER DISC (CD). Please pick this up by going to the facility where you had your XRAY study performed. Ask them to put all of your studies such as ultrasound, CT scan and MRI onto a CD. And bring that CD to us on the day of your appointment.

- ○ Requested and picked up imaging studies (ultrasound, CT scan, MRI) on CD

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Albany Urologic Oncology Pre-Visit Patient Form

- Please complete this form prior to your visit (3 pages).

Patient Name_____

Date of Birth _____ Phone _____

Address_____

Emergency Contact _____ Phone_____

Primary Physician_____

Phone _____ FAX_____

Pharmacy _____ Phone_____

Do you take any medications? Yes _____ No _____

If yes, please list all of your medications (include dosage and frequency taken):

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Do you have any allergies to medication? Yes _____ No _____

If yes, please list your medication allergies:

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Please Circle the Appropriate Answer:

High blood pressure	Yes ____	No ____	Cancer	Yes ____	No ____
High cholesterol	Yes ____	No ____	Site(s): _____		
Chest pain or angina	Yes ____	No ____	Gastroesophageal reflux	Yes ____	No ____
Heart attack	Yes ____	No ____	Liver disease	Yes ____	No ____
Heart rhythm problem	Yes ____	No ____	Hepatitis	Yes ____	No ____
Congestive heart failure	Yes ____	No ____	HIV	Yes ____	No ____
Diabetes	Yes ____	No ____	Kidney disease	Yes ____	No ____
Thyroid problems	Yes ____	No ____	Urinary/Prostate problems	Yes ____	No ____
Asthma	Yes ____	No ____	Blood clots in leg or lung	Yes ____	No ____
COPD/Emphysema	Yes ____	No ____	Bleeding disease	Yes ____	No ____
Pneumonia	Yes ____	No ____	Blood transfusions	Yes ____	No ____

Sleep apnea	Yes ____	No ____	Poor blood flow to legs	Yes ____	No ____
Migraines	Yes ____	No ____	Arthritis	Yes ____	No ____
Seizures	Yes ____	No ____	Do you smoke?	Yes ____	No ____
Stroke	Yes ____	No ____	How much? _____		
Anxiety disorder	Yes ____	No ____	When did you quit? _____		
Depression	Yes ____	No ____	Do you use alcohol?	Yes ____	No ____
Anesthetic Complication	Yes ____	No ____	How much? _____		
Autoimmune disorder	Yes ____	No ____	Do you use illicit drugs?	Yes ____	No ____

Surgical History_____

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Family History_____

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