NEW YORK MEN'S HEALTH
Peter N. Schlegel, M.D.

MEDICAL INFORMATION RELEASE

I _____, a patient of Peter N. Schlegel, MD at New York Men's Health Medical, hereby authorize the release of my medical information and test results to my spouse/partner _____ and our physicians if needed.

Signature: _____

Date:_____

Peter N. Schlegel, M.D.

Phone: 212-746-5491: Fax: 212-746-8425

(Please fill out this form with ink. It will become part of your medical record)

Name: _____ Date: _____

History#_____Age: _____

Who referred you?: _____

Reason for your visit: Men's Health issues Prostate Cancer diagnosis/screening

Other: _____

Medical History: (please check off past or current medical problems)

Anemia	Asthma	Anxiety/Depression	Bleeding Disorder
Prostate Cancer	Bladder cancer	other cancer	Diabetes
Gall stones	Heart murmur	other heart disease	hemorrhoids
High blood pressure	hernia	incontinence	irritable bowel
Kidney disease	migraines	seizure disorder	thyroid disease
Blood clots	sexual problems	stroke	other

Childhood diseases: list any childhood disease which may have a bearing on your present health
i.e. mumps/infertility, rheumatic fever/heart disease, etc.

Surgical History:

Name of Procedure	Date of Procedure	Reason of Procedure

Current Medications:

Medications	Dose	#of times taken daily

Are you allergic to any medications? Yes No
If yes, please list medication and reaction:

Family History: Please answer Yes or No and list the family member that has the history.

Yes or No	Disease	Family Member (who i.e.:mother, father etc.)
	Prostate Cancer	
	Bladder Cancer	
	Colon Cancer	
	TB	
	Thyroid	
	Diabetes	
	Kidney Disease	
	High Blood Pressure	
	Heart Disease	
	Birth Defects	
	Cystic Fibrosis	
	Hormone Problems	
	Fertility Problems	
	Other	
	No Significant History	

Social History:

Occupation: _____ Marital Status _____

Children: YES NO How Many _____ Ages _____

Sexual Preference: Men _____ Women _____ Both_____

Diet: Salt _____ Special _____ Vegetarian _____

Regular Exercise routine? Yes/No If yes, describe _____

Smoking: (list # of packs per day and years) _____

Alcohol: (list how many drinks per week) _____

Caffeine: (# of cups daily) _____

Marijuana or other drugs: _____

Other relevant social issues for Dr. Schlegel to know:_____

Review of Systems:

Constitutional:		
Significant change in weight	Yes	No
Fever and chills	Yes	No
Fatigue or malaise	Yes	No
HEENT:		
Persistent headaches	Yes	No
Visual problems	Yes	No
Ringing in your ears	Yes	No
Cardiovascular:		
Shortness of breath	Yes	No
Chest pain	Yes	No
Palpitations	Yes	No
Respiratory:		
Cough	Yes	No
Wheezing	Yes	No
Gastrointestinal:		
Nausea and Vomiting	Yes	No
Diarrhea or constipation	Yes	No
Other	Yes	No
Genito-urinary:		
Burning or discomfort on urination	Yes	No
Blood in urine	Yes	No
Incontinence of Urine	Yes	No
Musculoskeletal:		
Muscle weakness or other symptoms	Yes	No

Skin:		
Skin rash or lesions	Yes	No
Neurological:		
Loss of consciousness	Yes	No
Seizures	Yes	No
Numbness or tingling	Yes	No
Psychiatric:		
Depression	Yes	No
Anxiety	Yes	No
Other:	Yes	No
Hematologic/lymph:		
Easy bruising	Yes	No
Unusual bleeding	Yes	No
Allergy/Immunology:		
Allergies	Yes	No

Please list any additional information that you feel is relevant for your medical records:

Physicians Notes:

_____

Peter N. Schlegel, M.D.