

# ARKANSAS UROLOGY UPDATE FORM

Date: \_\_\_\_\_ Doctor: \_\_\_\_\_

Patient Name: \_\_\_\_\_

If child - Parents Names: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone #: \_\_\_\_\_

Primary Care/Family Physician: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone #: \_\_\_\_\_

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

Address \_\_\_\_\_

\_\_\_\_\_

Phone #: \_\_\_\_\_

Pharmacy/Drug Store: \_\_\_\_\_

Phone #: \_\_\_\_\_

If you use a mail order pharmacy please write your pharmacy ins. ID #: \_\_\_\_\_

\_\_\_\_\_

Name of Insurance Company: \_\_\_\_\_

ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_

ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Third Insurance: \_\_\_\_\_

ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

# ARKANSAS UROLOGY UPDATE FORM

## CURRENT MEDICATIONS

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_
7. \_\_\_\_\_
8. \_\_\_\_\_
9. \_\_\_\_\_
10. \_\_\_\_\_
11. \_\_\_\_\_
12. \_\_\_\_\_
13. \_\_\_\_\_

XRays/PSAs/Tests done elsewhere since last here? \_\_\_\_\_

Where? \_\_\_\_\_

New Urology Problems? \_\_\_\_\_

Other Problems? \_\_\_\_\_

Reason for visit: \_\_\_\_\_

**ALLERGIES:** \_\_\_\_\_

**New Medical Diagnosis since last visit:** \_\_\_\_\_

**New Surgical History since last visit:** \_\_\_\_\_

## REVIEW OF SYSTEMS – Please circle all that apply or none of the below

- |                              |                    |                                    |
|------------------------------|--------------------|------------------------------------|
| Abdominal Pain               | Coughing up Blood  | Shortness of Breath                |
| Black/Tarry Stools           | Difficulty Hearing | Skin Rash                          |
| Bleeding Tendencies          | Fever/Night sweats | Swollen Joints                     |
| Blood in Bowel Movements     | Headaches          | Visual Disturbances                |
| Blood in Urine               | Nausea/Vomiting    | Vomiting Blood                     |
| Chest Pain                   | Pain w/urination   | Weight loss/gain                   |
| Clay Colored Bowel Movements | Poor Circulation   | High Blood Pressure                |
| Pain Y / N Location _____    |                    | Level of Pain 1 2 3 4 5 6 7 8 9 10 |

Physician Signature & Date: \_\_\_\_\_

Physician Signature Review Date: \_\_\_\_\_

Physician Signature Review Date: \_\_\_\_\_

Physician Signature Review Date: \_\_\_\_\_