

ARKANSAS UROLOGY UPDATE FORM

NAME: _____

DATE: _____

ADDRESS: _____

HOME PH: _____

CELL PH: _____

INSURANCE: _____

CURRENT MEDICATIONS

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

8. _____

9. _____

10. _____

ALLERGIES: _____

MEDICAL HISTORY

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

8. _____

XRAYs/PSAs/TESTS DONE ELSEWHERE SINCE YOUR LAST VISIT?

WHERE? _____

NAME AND NUMBER OF YOUR PHARMACY? _____

PRIMARY CARE PHYSICIAN? _____

NEW UROLOGY PROBLEMS? _____

SURGICAL HISTORY

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

8. _____

REVIEW OF SYSTEMS – PLEASE CIRCLE ALL THAT APPLY *(or circle none of the below):*

ABDOMINAL PAIN
BLACK/TARRY STOOLS
BLEEDING TENDENCIES
BLOOD IN BMs
BLOOD IN URINE
CHEST PAIN
CLAY COLORED BMs

COUGHING UP BLOOD
DIFFICULTY HEARING
FEVER/NIGHT SWEATS
HEADACHES
NAUSEA/VOMITING
PAIN WITH URINATION
POOR CIRCULATION

SHORTNESS OF BREATH
SKIN RASH
SWOLLEN JOINTS
VISUAL DISTURBANCES
VOMITING BLOOD
WEIGHT LOSS/GAIN
HIGH BLOOD PRESSURE
NONE OF THE ABOVE

OTHER PROBLEMS: _____

REASON FOR VISIT: _____

PATIENT'S SIGNATURE: _____