



Social Security Number

\_\_\_\_/\_\_\_\_/\_\_\_\_

Please fill in dots completely.

● correct

● incorrect

## FEMALE VOIDING SYMPTOMS

Please darken the circle yes(Y) or no (N) of the choice which best describes your answer to the following questions.

- | Y                     | N                     |   |
|-----------------------|-----------------------|---|
| <input type="radio"/> | <input type="radio"/> | Do you have <u>discomfort</u> with urination?   |
| <input type="radio"/> | <input type="radio"/> | Do you have <u>pain or pressure</u> in the bladder that is relieved by urinating?                               |
| <input type="radio"/> | <input type="radio"/> | Do you have <u>urinary tract infections</u> ?   |
|                       |                       | If yes, <input type="radio"/> very rarely   |
|                       |                       | <input type="radio"/> 1-2 times per year  |
|                       |                       | <input type="radio"/> 3 or more times per year  |
| <input type="radio"/> | <input type="radio"/> | Do you have <u>blood</u> in your urine?   |
| <input type="radio"/> | <input type="radio"/> | Do you have sudden <u>urges to urinate</u> ?  |
| <input type="radio"/> | <input type="radio"/> | Do you have <u>leakage</u> with sudden urges to urinate? ( <u>urgency incontinence</u> )                        |
| <input type="radio"/> | <input type="radio"/> | Do you <u>leak</u> urine with coughing, sneezing, lifting, or activity? ( <u>stress incontinence</u> )          |
| <input type="radio"/> | <input type="radio"/> | Do you have <u>leakage of which you are unaware</u> (i.e. you are wet but are not sure when it <u>occurs</u> )? |
| <input type="radio"/> | <input type="radio"/> | Do you wear <u>pads or change clothes</u> because of urine leakage?   |
|                       |                       | How many pads per day? _____  |
| <input type="radio"/> | <input type="radio"/> | Is your urinary <u>flow intermittent</u> (stop and go)?   |
| <input type="radio"/> | <input type="radio"/> | Do you have a <u>bulge</u> from your vagina?  |
| <input type="radio"/> | <input type="radio"/> | While you are awake, how often do you urinate on average?   |
|                       |                       | <input type="radio"/> more frequently than every ½ hour   |
|                       |                       | <input type="radio"/> every ½ hour to 1 hour  |
|                       |                       | <input type="radio"/> every 1 to 2 hours  |
|                       |                       | <input type="radio"/> every 2 to 3 hours  |
|                       |                       | <input type="radio"/> longer than every 3 hours   |
| <input type="radio"/> | <input type="radio"/> | On average, how many times a night do you wake up to void?  |
|                       |                       | <input type="radio"/> none  |
|                       |                       | <input type="radio"/> one   |
|                       |                       | <input type="radio"/> two   |
|                       |                       | <input type="radio"/> three   |
|                       |                       | <input type="radio"/> four  |
|                       |                       | <input type="radio"/> five  |
|                       |                       | <input type="radio"/> six or more   |
| <input type="radio"/> | <input type="radio"/> | Do you <u>snore</u> ?   |
| <input type="radio"/> | <input type="radio"/> | Does it ever <u>wake you up</u> ?   |

**REVIEW OF SYSTEMS (FEMALE)**

Do you now or have you had any problems related to the following symptoms? Darken the circle Y (yes) when the symptom is present or N (no) when not present. Please mark yes or no for each choice.

<p><b>GENITOURINARY</b></p> <p><b>Y N</b></p> <p><input type="radio"/> <input type="radio"/> Burning with urination</p> <p><input type="radio"/> <input type="radio"/> Blood in urine</p> <p><input type="radio"/> <input type="radio"/> Leakage of urine</p> <p><input type="radio"/> <input type="radio"/> Nighttime voiding: _____ times a night</p> <p><input type="radio"/> <input type="radio"/> Pelvic Pain</p> <p><input type="radio"/> <input type="radio"/> Vaginal discharge</p> <p><input type="radio"/> <input type="radio"/> Painful intercourse</p> <p><input type="radio"/> <input type="radio"/> Flank pain <input type="radio"/> Left <input type="radio"/> Right</p>	<p><b>INTEGUMENTARY</b></p> <p><b>Y N</b></p> <p><input type="radio"/> <input type="radio"/> Skin Rash</p> <p><input type="radio"/> <input type="radio"/> Boils</p> <p><input type="radio"/> <input type="radio"/> Varicose Veins</p>
<p><b>CONSTITUTIONAL</b></p> <p><b>Y N</b></p> <p><input type="radio"/> <input type="radio"/> Fever</p> <p><input type="radio"/> <input type="radio"/> Chills</p> <p><input type="radio"/> <input type="radio"/> Headaches</p> <p><input type="radio"/> <input type="radio"/> Unexplained weight loss</p>	<p><b>NEUROLOGICAL</b></p> <p><b>Y N</b></p> <p><input type="radio"/> <input type="radio"/> Tremors</p> <p><input type="radio"/> <input type="radio"/> Dizzy Spells</p> <p><input type="radio"/> <input type="radio"/> Numbness/Tingling</p>
<p><b>EYES</b></p> <p><b>Y N</b></p> <p><input type="radio"/> <input type="radio"/> Impaired Vision</p> <p><input type="radio"/> <input type="radio"/> Pain in eyes</p>	<p><b>PSYCHIATRIC</b></p> <p><b>Y N</b></p> <p><input type="radio"/> <input type="radio"/> Do You Have a Depressed Mood?</p> <p><input type="radio"/> <input type="radio"/> Are You Overly Anxious?</p>
<p><b>EARS, NOSE, MOUTH, THROAT</b></p> <p><b>Y N</b></p> <p><input type="radio"/> <input type="radio"/> Ear Infection</p> <p><input type="radio"/> <input type="radio"/> Sore Throat</p> <p><input type="radio"/> <input type="radio"/> Sinus Problems</p>	<p><b>ENDOCRINE</b></p> <p><b>Y N</b></p> <p><input type="radio"/> <input type="radio"/> Excessive Thirst</p> <p><input type="radio"/> <input type="radio"/> Too Hot / Cold</p> <p><input type="radio"/> <input type="radio"/> Tired / Sluggish</p>
<p><b>CARDIOVASCULAR</b></p> <p><b>Y N</b></p> <p><input type="radio"/> <input type="radio"/> Chest Pain</p> <p><input type="radio"/> <input type="radio"/> High Blood Pressure</p> <p><input type="radio"/> <input type="radio"/> Swelling in Extremities</p>	<p><b>HEMATOLOGIC / LYMPHATIC</b></p> <p><b>Y N</b></p> <p><input type="radio"/> <input type="radio"/> Swollen Glands</p> <p><input type="radio"/> <input type="radio"/> Blood Clotting Problems</p>
<p><b>RESPIRATORY</b></p> <p><b>Y N</b></p> <p><input type="radio"/> <input type="radio"/> Wheezing</p> <p><input type="radio"/> <input type="radio"/> Frequent Coughing</p> <p><input type="radio"/> <input type="radio"/> Shortness of Breath</p>	<p><b>ALLERGIC / IMMUNOLOGIC</b></p> <p><b>Y N</b></p> <p><input type="radio"/> <input type="radio"/> Hay Fever</p> <p><input type="radio"/> <input type="radio"/> Drug Allergies</p>
<p><b>GASTROINTESTINAL</b></p> <p><b>Y N</b></p> <p><input type="radio"/> <input type="radio"/> Abdominal Pain</p> <p><input type="radio"/> <input type="radio"/> Nausea / Vomiting</p> <p><input type="radio"/> <input type="radio"/> Diarrhea or Loose Stool</p> <p><input type="radio"/> <input type="radio"/> Blood in Stool</p>	<p><b>Physician Use Only: (Comments / Notes)</b></p> <hr/> <hr/> <hr/> <hr/>
<p><b>MUSCULOSKELETAL</b></p> <p><b>Y N</b></p> <p><input type="radio"/> <input type="radio"/> Chronic Neck Pain</p> <p><input type="radio"/> <input type="radio"/> Chronic Back Pain</p> <p><input type="radio"/> <input type="radio"/> Pain that Radiates Down Leg Which Side? <input type="radio"/> Right? <input type="radio"/> Left? <input type="radio"/> Both?</p> <p><input type="radio"/> <input type="radio"/> Arthritis</p>	

**PAST MEDICAL HISTORY**

**Section 1**

Do you now or have you had the following illnesses? Fill in the circle (Yes or No) and please Give the approximate date when requested. *Please mark yes or no for each choice.*

<b>Y</b>	<b>N</b>									
<input type="radio"/>	<input type="radio"/>	Urinary tract problem	→	1) What type?	_____	When?	_____			
				2) What type?	_____	When?	_____			
<input type="radio"/>	<input type="radio"/>	Bleeding	→	What type?	_____	When?	_____			
<input type="radio"/>	<input type="radio"/>	Cancer	→	1) What type?	_____	When?	_____			
				2) What type?	_____	When?	_____			
<input type="radio"/>	<input type="radio"/>	Hepatitis	→	What type?	_____	When?	_____			
<input type="radio"/>	<input type="radio"/>	Stroke	→	When?	_____					
<input type="radio"/>	<input type="radio"/>	Heart Attack (MI)	→	When?	_____					
<input type="radio"/>	<input type="radio"/>	Heart Disease								
<input type="radio"/>	<input type="radio"/>	Heart Failure								
<input type="radio"/>	<input type="radio"/>	Irregular Heartbeat								
<input type="radio"/>	<input type="radio"/>	High Blood Pressure								
<input type="radio"/>	<input type="radio"/>	Diabetes								
<input type="radio"/>	<input type="radio"/>	HIV								
<input type="radio"/>	<input type="radio"/>	Emphysema								
<input type="radio"/>	<input type="radio"/>	Pneumonia	→	When?	_____					
<input type="radio"/>	<input type="radio"/>	Asthma								
<input type="radio"/>	<input type="radio"/>	Anemia								
<input type="radio"/>	<input type="radio"/>	Seizure								
<input type="radio"/>	<input type="radio"/>	Kidney Stones								
<input type="radio"/>	<input type="radio"/>	Kidney Disease	→	What type?	_____					
<input type="radio"/>	<input type="radio"/>	Gout								
<input type="radio"/>	<input type="radio"/>	Glaucoma								
<input type="radio"/>	<input type="radio"/>	Thyroid Disease								
<input type="radio"/>	<input type="radio"/>	Arthritis								
<input type="radio"/>	<input type="radio"/>	Ulcer								
<input type="radio"/>	<input type="radio"/>	Blood Disorder	→	What type?	_____					
<input type="radio"/>	<input type="radio"/>	Sickle Cell								
<input type="radio"/>	<input type="radio"/>	Mental Illness / Condition	→	What type?	_____					
<input type="radio"/>	<input type="radio"/>	Neurological Condition	→	What type?	_____					
<input type="radio"/>	<input type="radio"/>	Gallstones								
<input type="radio"/>	<input type="radio"/>	Gastroesophageal reflux ("GERD")								
<input type="radio"/>	<input type="radio"/>	Are you pregnant now?		When was your last period?	_____					
<input type="radio"/>	<input type="radio"/>	Have you been pregnant before?								
				How many vaginal deliveries?	<input type="radio"/> 01	<input type="radio"/> 02	<input type="radio"/> 03	<input type="radio"/> 04	<input type="radio"/> 05	<input type="radio"/> 0>6
				How many C-section deliveries?	<input type="radio"/> 01	<input type="radio"/> 02	<input type="radio"/> 03	<input type="radio"/> 04	<input type="radio"/> 05	<input type="radio"/> 0>6

Other Serious Illnesses, Injuries or Treatments: \_\_\_\_\_

**PAST SURGICAL HISTORY: Fill in the appropriate circle and give date.**

**HYSTERECTOMY**

<input type="radio"/>	<input type="radio"/>	When?	_____
		If "yes", what type?	
<input type="radio"/>	<input type="radio"/>	Abdominal (scar lower abdomen)	
<input type="radio"/>	<input type="radio"/>	Vaginal	

**BLADDER SURGERY**  
(for incontinence or leaking)

<input type="radio"/>	<input type="radio"/>	When?	_____
		If "yes", what type?	
<input type="radio"/>	<input type="radio"/>	Burch or MMK (scar lower abdomen)	
<input type="radio"/>	<input type="radio"/>	Vaginal Incision	
<input type="radio"/>	<input type="radio"/>	Pubovaginal Sling	
<input type="radio"/>	<input type="radio"/>	Transobturator Sling	
<input type="radio"/>	<input type="radio"/>	Not Sure	

**VAGINAL SURGERY**

<input type="radio"/>	<input type="radio"/>	When?	_____
		If "yes", what type?	
<input type="radio"/>	<input type="radio"/>	Cystocele "Anterior Repair"	
<input type="radio"/>	<input type="radio"/>	Rectocele "Posterior Repair"	
<input type="radio"/>	<input type="radio"/>	Enterocoele	
		Other	_____

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\_\_\_\_/\_\_\_\_/\_\_\_\_

PAST SURGICAL HISTORY (CONT)

**KIDNEY STONE SURGERY**

Y N  
  If yes, how many total times? \_\_\_\_\_  
 If "yes", check all that apply:  
  Stone Extraction with Scope When? \_\_\_\_\_  
  ESWL (Shockwave Lithotripsy - no scope) When? \_\_\_\_\_  
  Stent Only When? \_\_\_\_\_  
  Open Surgical Removal (big scar) When? \_\_\_\_\_  
  Percutaneous Removal (small scar in flank/side) When? \_\_\_\_\_  
 Other \_\_\_\_\_

**KIDNEY SURGERY**

Y N  
  Nephrectomy When? \_\_\_\_\_ Why? \_\_\_\_\_  
   Right  
  Left  
  Stone Surgery  
  Other Kidney Surgery What Type? \_\_\_\_\_

**HERNIA**

Y N  
  \_\_\_\_\_ > When? \_\_\_\_\_  
 If "yes", what type?  
 Right inguinal / groin  
 Left inguinal / groin  
 Incisional (in an old scar)  
 Umbilical (belly button)  
 Other What Type? \_\_\_\_\_

**GALLBLADDER SURGERY**

Y N  
  \_\_\_\_\_ > When? \_\_\_\_\_  
 If "yes", what type?  
 Laparoscopic Surgery (small scars)  
 Open (big scar)

**APPENDIX SURGERY**

Y N  
  \_\_\_\_\_ > When? \_\_\_\_\_  
 If "yes", what type?  
 Laparoscopic Surgery (small scars)  
 Open (big scar)

**HEART SURGERY**

Y N  
  \_\_\_\_\_ > When? \_\_\_\_\_  
 If "yes", what type?  
 Bypass  
 Heart Valve  
 Angioplasty / Stent  
 Other What Type? \_\_\_\_\_

**BACK SURGERY**

Y N  
  \_\_\_\_\_ > When? \_\_\_\_\_

**NECK SURGERY**

Y N  
  \_\_\_\_\_ > When? \_\_\_\_\_

**VASCULAR SURGERY**  
(Blood Vessel)

Y N  
  \_\_\_\_\_ > When? \_\_\_\_\_  
 What Kind? \_\_\_\_\_

Other - Please List Type of Surgery with Date:

\_\_\_\_\_  
\_\_\_\_\_

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MEDICATIONS – Do you take any medications? (Include aspirin and vitamin supplements)

YES  NO

If yes, please list:

Medication

Dosage or Amount

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Note: If you need more space, please ask for an additional medication sheet.

Do you take?

Y N

Blood Thinner? (e.g. Aspirin, Coumadin, Plavix)

What Types? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

ALLERGIES:

Y N

Please list medications to which you are allergic:

Type of Reaction(s):

Nausea

Rash

Swelling

Breathing

Other

Problems

(Describe)

	Nausea	Rash	Swelling	Breathing	Other Problems	(Describe)
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

Note: If you need to list more allergies, please ask for an additional allergy sheet.

Y N

Are you allergic to x-ray dye? What type of reaction? \_\_\_\_\_

Are you allergic to iodine or seafood? What type of reaction? \_\_\_\_\_

Are you allergic to latex? What type of reaction? \_\_\_\_\_

SECTION II

FAMILY HISTORY:

If the answer to any of these questions is yes, please tell which relative.

Do you have a family history of

Y N

Cancer of the kidneys, ureters, bladder, or any other part of the urinary tract?

Relative? \_\_\_\_\_

Type? \_\_\_\_\_

Urinary tract infections?

Relative? \_\_\_\_\_

Kidney stones?

Relative? \_\_\_\_\_

Kidney disease?

Relative? \_\_\_\_\_

Type? \_\_\_\_\_

Hematuria/blood in urine?

Relative? \_\_\_\_\_

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**SECTION III  
SOCIAL HISTORY**

Marital Status:     Married             Single             Divorced             Widowed             Separated

Occupation when working? \_\_\_\_\_

Retired?             Y     N                      Disabled?             Y     N  
If "yes", why are you disabled? \_\_\_\_\_

Y   N  
O   O    Do you drink beverages with caffeine?            Please enter the approximate number per day:

Colas? \_\_\_\_\_  
Cups of coffee? \_\_\_\_\_  
Glasses of tea? \_\_\_\_\_

Y   N  
O   O    Do you drink alcohol?                                      What Type? \_\_\_\_\_  
Amount? \_\_\_\_\_

Y   N  
O   O    Do you smoke or chew tobacco products?            What Type? \_\_\_\_\_  
Amount? \_\_\_\_\_

Y   N  
O   O    Have you had exposure to industrial / farm  
chemicals or industrial dyes?                              What Type? \_\_\_\_\_  
When? \_\_\_\_\_

Y   N  
O   O    Do you have a special diet?                              What Type? \_\_\_\_\_

Thank you for your time and cooperation!

**Arkansas Urology reviews patient records as a part of our ongoing process to  
improve patient services as well as assist with research. Do we have your  
permission to use your information in an anonymous manner?  
(In other words, we will not use your name.)**

Y   N  
O   O

Patient Signature: \_\_\_\_\_

Physician Signature: \_\_\_\_\_

# PATIENT REGISTRATION

**ARKANSAS UROLOGY, P.A.**

ACCT.# \_\_\_\_\_

CLINIC LOCATION \_\_\_\_\_

Date \_\_\_\_\_ Appt. Time \_\_\_\_\_

Pharmacy \_\_\_\_\_

Today's appt. is with Dr. \_\_\_\_\_

Pharmacy phone \_\_\_\_\_

## PATIENT INFORMATION

Name \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

Mailing Address \_\_\_\_\_

Social Security \_\_\_\_\_

Physical Address \_\_\_\_\_

Patient Place of Employment \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Spouse/Parent Name \_\_\_\_\_

Pager # \_\_\_\_\_ Cell Phone \_\_\_\_\_

Spouse/Parent Work # \_\_\_\_\_

E-Mail \_\_\_\_\_

Name and phone # next of kin not living with you \_\_\_\_\_

## PERSON RESPONSIBLE FOR BILL

Name \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Address \_\_\_\_\_

Relation to Patient \_\_\_\_\_

## OTHER INFORMATION

Who referred you to this clinic? Doctor \_\_\_\_\_ Specialty \_\_\_\_\_ City \_\_\_\_\_

Family Member  Friend Name \_\_\_\_\_  Yellow Pages  Advertisement  Referral Service

Have you ever seen any of our doctors as a patient before? \_\_\_\_\_ In Office \_\_\_\_\_ In Hosp. \_\_\_\_\_

Allergies \_\_\_\_\_ Latex Allergy:  Yes  No

Reason for Visit \_\_\_\_\_

## INSURANCE INFORMATION

Primary Insurance Carrier \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Address to mail claims \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_ Program # \_\_\_\_\_

Policyholder Name \_\_\_\_\_ Address \_\_\_\_\_

Policyholder Phone \_\_\_\_\_ Policyholder Birthdate \_\_\_\_\_ Sex \_\_\_\_\_

Policyholder Employer/School \_\_\_\_\_

Policyholder Relationship to Patient \_\_\_\_\_ Policyholder SSN \_\_\_\_\_

Does your primary insurance require Pre-Authorization/Pre-certification?  Yes  No

Are referrals from primary care physician required?  Yes  No Primary Physician's Name \_\_\_\_\_

Secondary Insurance Carrier \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Address to mail claims \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_ Program # \_\_\_\_\_

Policyholder Name \_\_\_\_\_ Address \_\_\_\_\_

Policyholder Phone \_\_\_\_\_ Policyholder Birthdate \_\_\_\_\_ Sex \_\_\_\_\_

Policyholder Employer/School \_\_\_\_\_

Policyholder Relationship to Patient \_\_\_\_\_ Policyholder SSN \_\_\_\_\_

Is this policy: A. Medicare Supplemental Policy  or B. Employer Sponsored  Do you have papers from attorney / Work. Comp?  Yes  No

## MEDICAL RELEASE INFORMATION

I Authorize the release of any medical information necessary to process insurance claims for services and/or supplies provided by Arkansas Urology, P.A.

### PAYMENT OF BENEFITS

I Authorize payment of medical benefits to Arkansas Urology for services and/or supplies provided by them.

### ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

I Understand and agree that, (regardless status), I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information.

X \_\_\_\_\_

Date \_\_\_\_\_

**ARKANSAS UROLOGY, P.A.**  
**3401 Springhill Drive · Suite 345**  
**North Little Rock, AR 72117**

**ACKNOWLEDGEMENT**

By my signature below, I acknowledge that I have received a copy of the Arkansas Urology, P.A.'s  
*Notice of Privacy Practices.*

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Patient Signature

# Arkansas Urology Pre-Procedure Questionnaire

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Date: \_\_\_\_\_ DR: \_\_\_\_\_

- 1) Do you see a Heart Doctor? Yes\_\_\_ No\_\_\_  
If yes, for what condition \_\_\_\_\_  
Please list physicians name and address \_\_\_\_\_
- 2) Do you see a Lung Doctor? Yes\_\_\_ No\_\_\_  
If yes, for what condition \_\_\_\_\_  
Please list physicians name and address \_\_\_\_\_
- 3) When was the last time you saw your doctor for these conditions?  
\_\_\_\_\_
- 4) Do you have any of the following conditions and when did it occur?

A) Heart Attack	Yes___	No___	When_____
B) Bypass Surgery	Yes___	No___	When_____
C) Pacemaker	Yes___	No___	When_____
D) Defibrillator	Yes___	No___	When_____
E) Heart or Leg Stent	Yes___	No___	When_____
F) Heart Murmur	Yes___	No___	When_____
G) Valve Replacement	Yes___	No___	When_____
H) Lung Surgery	Yes___	No___	When_____
- 5) Do you use Oxygen? Yes\_\_\_ No\_\_\_
- 6) Do you have Sleep Apnea and/or use a C-PAP? Yes\_\_\_ No\_\_\_
- 7) Do you take Coumadin (Warfarin), Plavix, Platel, Aspirin(including Ibuprophen), Arthritis Medicine, Vitamin E, or any other medicines that might thin your blood?  
NO\_\_\_ If YES, list them here \_\_\_\_\_

The above information has been provided to the best of my knowledge to  
Arkansas Urology, P.A.

Sign: \_\_\_\_\_ Date: \_\_\_\_\_

## Arkansas Urology Update Form

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

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

**Doctor Sign Off**

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

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

**Primary Insurance Company:** \_\_\_\_\_

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

**Secondary Insurance Company:** \_\_\_\_\_

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

**Pharmacy name & phone:** \_\_\_\_\_

**Referring DR:** \_\_\_\_\_ **PCP:** \_\_\_\_\_

**Medications:**

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Medical Conditions:**

_____	_____	_____
_____	_____	_____
_____	_____	_____

**Surgical History:**

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Allergies:**

_____	_____	_____
_____	_____	_____

**Patient Signature:** \_\_\_\_\_