NORTHWEST ARKANSAS UROLOGY ASSOCIATES
NEW PATIENT HISTORY FORM

Name: ____**Today's Date:** ______________________

Date of Birth: __________________________________ **SSN:** ________________________________

Referring Doctor: _____________________________ **Family Doctor:** _____________________________

Why are you seeing the doctor today? ____

____

How long have you had this problem? ____

What improves or worsens the problem? ____

Please describe your symptoms and pain related to this problem: ____

____

Have you tried any medicine/treatment for this problem/pain? ____

<u>CURRENT MEDICATIONS</u> – **Please list ALL medications you are currently taking including over the counter meds**

Drug Name:	Strength:	Directions/How you take it:
______________________________	____________	____
______________________________	____________	____
______________________________	____________	____
______________________________	____________	____
______________________________	____________	____
______________________________	____________	____
______________________________	____________	____
______________________________	____________	____
______________________________	____________	____
______________________________	____________	____
______________________________	____________	____
______________________________	____________	____
______________________________	____________	____
______________________________	____________	____

Attach list if necessary

Pharmacy Name/Location: ______________________________________**Street:** ____

<u>ALLERGIES</u> – **Please list ALL types (Drug, seasonal, pets, environmental, foods)**

____

____

Any recent imaging (cat scan, ultrasound, xray, MRI, etc.) If so, where:____

____

OVER

NORTHWEST ARKANSAS UROLOGY ASSOCIATES
NEW PATIENT HISTORY FORM

Name: ____

SOCIAL HISTORY

Please provide the following information:

Marital Status: Please indicate years

______ Single ______Married ______Separated _____Divorced _____Widowed _____Life Partner ____Common Law Spouse

Dependants: Please indicate # of each that you are *responsible to care for:*

_____Sons ______Daughters ______Stepchildren ______Adopted ______Foster ______Parents _______Grandparents

Occupation: Please circle one that applies:

None, Laborer, Truck Driver, Tradesman, Clerk, Administrative, Executive, Professional, Part-Time, Retired, Other

Do you drink alcohol? Y/N How Often? Rarely Daily Occasionally Never

Do you smoke/chew tobacco? Y/N Packs per day? _________

If you previously smoked or chewed, when did you stop? __________________________

Recreational Drugs: ______None If yes, please list: ____

Caffeinated beverages: None Low Moderate Excessive

REVIEW OF SYSTEMS: (Please circle if you have or currently experience)

Constitutional
Appetite increase
Appetite decrease
Chills
Fever
Fatigue
Generalized Weakness
Insomnia
Easy Bruising
Weight Loss
____

Eyes
Blindness
Blurred Vision
Double Vision
Pain
____

Neurological
Disoriented
Dizzy Spells
Headache
Memory Loss
Numbness/Tingling
Stroke
Speech Problems
Tremors

Endocrine
Excessive thirst
Too Hot/Cold
____

Gastrointestinal
Abdominal Pain
Bloody Stools
Change in Bowel Habits
Constipation
Diarrhea
Hemorrhoids
Indigestion/heartburn
____

Cardiovascular
Chest Pain
Leg crams with walking
Palpitation (racing heart)
Swelling of legs
Difficulty laying flat
____

Skin
Acne
Boils
Changing Moles
Persistent Itch
Skin rash
____

Musculoskeletal
Back Pain
Joint Pain
____

Ear/Nose/Throat
Ear pain
Sinus Problem
Sore Throat
____

Genitourinary
Bedwetting
Blood in Urine
Burning on Urination
Erection Problems
Urgency
Urinary Frequency
Urinary Hesitancy
Urinary Incontinence
Incomplete bladder emptying
Vaginal Bleeding
Penile/Vaginal Discharge
Weak Stream
____

Respiratory
Frequent Cough
Shortness of breath
Wheezing
____

Hematological/ Lymphatic
Swollen Glands
Blood clotting problem
____

Psychological
Anxiety
Depressed
Generally satisfied with life
____

Other: ____

____

If none of these apply, please initial here so we know this section has been reviewed by you. ______________________

NORTHWEST ARKANSAS UROLOGY ASSOCIATES
NEW PATIENT HISTORY FORM

Name: ____

PAST MEDICAL HISTORY

Please CIRCLE if you have or have had any of the following diseases or conditions:

Cardiovascular
Anemia
Aortic Aneurysm
Arrhytmia
Atrial Fibrillation
Cerebrovascular Disease
Congenital Heart Disease
Congestive Heart Failure
Coronary Artery Disease
Deep Vein Thrombosis
Endocarditis
Heart Attack
Heart Murmur
Heart Valve Disease
High Blood Pressure
Stroke
Varicose Veins

Endocrine/Metabolic
Diabetes
Gout
Thyroid Disease
Elevated Cholesterol/ Lipids

General
Exposure to Chemicals
Sleep Apnea

GI
Chronic Liver Disease
Colon Cancer
Crohn's Disease
Gallbladder Disease
Gastric Cancer
GERD
Hemorrhoids
Hepatitis – A, B or C
Hiatal Hernia
Pancreatitis
Pancreatic Cancer
Rectal Cancer
Ulcerative Colitis

GU
AIDS/HIV
Bladder Cancer
Bladder Infection
Bladder Prolapse
Blood in urine
Kidney Disease
Impotence
Interstitial Cystitis
Kidney Cancer
Kidney Disease
Kidney Infection
Kidney Stones
Libido Decreased
Neurogenic Bladder
Prostate Cancer
Testicular Cancer
Undescended Testicle
Ureteral Cancer
Urinary Tract Infection
Venereal Disease

GYN/OB
Abnormal PAP Smear
Breast Cancer
Cervical Cancer
Endometriosis
Menstrual Problems
Ovarian Cancer
Uterine Cancer

HEENT
Blindness
Cataracts
Deafness
Ear Infections
Glaucoma
Mumps
Sinusitis

Musculoskeletal
Arthritis
Carpal Tunnel Syndrome
Fibromyalgia

Neuro/Psych
ADD/ADHD
Alcoholism
Alzheimer's Disease
Bi-polar Disorder
Depression
Epilepsy
Migraine
Multiple Sclerosis
Parkinson's
Polio
Seizures
Spinal Cord Injury
Stroke

Respiratory
Asthma
Bronchitis
COPD
Emphysema
Lung Cancer
Pneumonia
Pulmonary Embolism
Tuberculosis

Tumors
Brain Tumor
Lymphoma
Melanoma
Sarcoidosis

Other

____
____

FEMALES ONLY

Menstrual History:

Are you or could you be pregnant? ____________________

LMP: (Date) ____________________ Menopause: (Date) __________________

Number of children, miscarriages, abortions (please include caesarean section or vaginal delivery:_______________________

Problems with pregnancies:____

Other: ____

If none of these apply, please initial here so we know that you have reviewed this section: __________________________

OVER

NORTHWEST ARKANSAS UROLOGY ASSOCIATES
NEW PATIENT HISTORY FORM

Name: ____

SURGICAL HISTORY

Please CIRCLE if you have had any of the following surgeries and approximate year of surgery:

Cardiovascular
Angioplasty
Aortic Aneurysm Repair
CABG
Carotid Artery Surgery
Heart Surgery (Stents)
Pacemaker Insertion
____

General
Brain Surgery
Lymph Node Surgery
Thyroid Surgery
____

GI
Appendix removal
Bariatric Surgery
(Weight Loss)
Bowel/Colon Surgery
Gallbladder Surgery
Hemorrhoid Surgery
Liver Surgery
Lysis Adhesions
Nissen Fundoplication
(Reflux surgery)
Spleen Surgery
Stomach Surgery
____

GU
Bladder Surgery
Biopsy Prostate
Circumcision
Scrotal/Testicular Surgery
Hernia Surgery
Interstim (Bladder
Pacemaker)
Kidney removed
Kidney Stone
Penile Implant
Prostate Surgery
Renal Transplant
Vasectomy
____

GYN
C-section
Hysterectomy-Partial
Hysterectomy-Total
Lumpectomy
Breast Surgery
Tubal Ligation
____

HEENT
Ear Surgery
Eye Surgery
Facial Surgery
Sinus Surgery
Tonsil Removal
Thyroid Surgery
____

Musculoskeletal
Amputation
Back/Disc Surgery
Carpal Tunnel Surgery
Cervical Spine Surgery
Foot Surgery
Hip Surgery
Knee Surgery
Shoulder Surgery
____

Respiratory
Lung Surgery
____

Skin
Basal Cell Carcinoma
Melanoma
Squamous Cell
Carcinoma
____

Other: ____

If none of these apply, please initial here so we know that you have reviewed this section: ____________________________

FAMILY HISTORY

Indicate which family member has/had any of the following:

(Mother, Father, Brother, Sister, Grandmother, Grandfather, Uncle, Aunt)

Arthritis ___________________________
Bladder Cancer ___________________________
Breast Cancer ___________________________
Colon Cancer ___________________________
Crohn's Disease ___________________________
Depression ___________________________
Diabetes ___________________________
Gout ___________________________
Heart Attack ___________________________
Hypertension ___________________________
Kidney Disease ___________________________
Kidney Stones ___________________________
Leukemia ___________________________
Malignant Melanoma ___________________________
Multiple Sclerosis ___________________________
Laryngeal Cancer ___________________________
Pancreatic Cancer ___________________________
Prostate Cancer ___________________________
Stroke ___________________________
Thyroid Disease ___________________________
Tuberculosis ___________________________

Other: ____

If you have no family history, please initial here so we know that you have reviewed this section: ____________________