ARK – LA – TEX UROLOGY *PATIENT HISTORY FORM*

Name _____ D.O.B. _____ Date: _____

Who are you seeing today (circle one) Dr. W. S. Bundrick, Jr. Dr. Christopher Wilson

Did another physician refer you to this office? **O** NO **O** YES If yes, whom: _____

Primary Care Physician: _____ phone #: _____

What Cardiologist/Pulmonologist do you see? _____
Location:_____

What is your pharmacy of choice? _____ phone #_____

What is the reason for today's visit? _____

PAST MEDICAL HISTORY

Do you have or have had any of the following problems?

O Allergies
O Arthritis
O Asthma
O BPH / Enlarged Prostate
O Bleeding Disorder
O Cancer _____
O Congestive Heart Failure
O COPD
O Coronary Artery Disease
O Depression
O Diabetes
O Diverticulitis Disease
O GERD
O Gout
O Headache / Migraines
O Hepatitis
O Hypertension
O IBS
O Heart Attack
O Osteoporosis
O Peptic Ulcer Disease
O Renal Disease
O Seizure disorder
O Stroke
O Thyroid Disease
O UTI's/Urinary Tract Infection
O Kidney Stones
O Aids
O Back pain / problems
O Bronchitis
O Cataracts
O Crohn's Disease
O Glaucoma
O HIV positive
O IV Drug Use (Ever)
O Liver Disease
O Lupus
O Mental Illness
O Alcoholism
O Osteoarthritis
O Parkinson's Disease
O Psoriasis
O Kidney failure
O MS
O Sickle Cell Disease
O Spinal Cord Injury
O Tuberculosis
O Rheumatic Fever

PAST SURGICAL HISTORY

Have you had any procedures or surgery in your life? **O** NO **O** YES
If yes, please list **type** of procedures or surgeries and **approximate date**

_____

_____

OB/GYN HISTORY

Last Menstrual Period (if applicable) _____
# of Pregnancies _____ # of Vaginal Deliveries _____ # of C-Sections _____

ALLERGIES

Are you allergic to any **medications**, shellfish or iodine? **O** NO **O** YES
If yes, please **list and describe your reaction** to the medication (hives, rash, etc.):

_____

_____

MEDICATIONS

Do you regularly take prescription or non-prescription medication? **O** NO **O** YES
If yes, please list all medicine, dosage and how many times per day:

_____ _____

_____ _____

_____ _____

FAMILY HISTORY

Has any relative (mother, father, sister, brother, paternal or maternal grandparents, maternal or paternal aunts or uncles) ever had any of the following? If so, please check and **state relation**:

O Asthma _____
O Blood Disease _____
O Cancer (**SPECIFY TYYPE**) _____
O Heart Disease _____
O Diabetes _____
O Gout _____
O High Blood Pressure _____
O Migraines _____
O Renal Failure _____
O Stroke _____
O Thyroid Disease _____
O UTI's _____
O Kidney Stones _____
O Other **(specify condition**) _____ _____

SOCIAL HISTORY

Do you or have you ever smoked? [ ] No [ ] Yes If yes, how many packs per day? _____
How many years have you been smoking? _____ If you quit, what age did you quit? _____
Do you drink alcohol? [ ] No [ ] Yes

What is your marital status? [ ] Married [ ] Single [ ] Divorced [ ] Widowed
Are you currently employed? [ ] No [ ] Yes Present or past occupation_____
What are your hobbies? _____