NORTH DALLAS UROLOGY ASSOCIATES/MCKINNEY

William C. Mitchell, MD
Jared D. Stringer, MD
972-548-8195

PATIENT HISTORY

****PLEASE COMPLETE AND BRING TO YOUR APPOINTMENT****

PATIENT NAME: ___________________________________ DATE: ______________

REFERRING DOCTORS NAME: ____

REASON FOR YOUR VISIT: ____
____

PREVIOUS SURGERIES/PREGNANCIES: ___________________________________
____

HAVE YOU EVER BEEN SEEN BY A UROLOGIST BEFORE? _________________

IF SO, WHO AND WHY? ____
____

PREVIOUS MEDICAL CONDITIONS (example, diabetes, up BP…) _______________
____

FAMILY HISTORY (stones, prostate cancer…..)_________________________________
____

CURRENT MEDICATIONS: ____
____

ALLERGIES: ____
PREVIOUS XRAYS, CT SCANS, MRI SCANS? _______________________________

ARE YOU A SMOKER? YES NO -IF YES, HOW MUCH? _________________

DO YOU CONSUME CAFFEINE? YES NO
IF YES HOW MUCH DO YOU CONSUME IN A DAY? _________________________

DO YOU CONSUME ALCOHOL? NEVER OCCASIONALLY DAILY