Pediatric Urology Child History Form

Patient's Last Name: _____ First Name: _____ Date of Birth: _____

Today's Date: _____ Referring Physician Name and address: _____

Chief Complaint: (Reason for visit today)_____

Duration of Problem: _____ Signs/Symptoms: _____

List anything that improves or worsens the problem: _____ Severity (scale from 1-10)_____

Medications (currently taking)

Name	Amount	Times/Day

Most commonly used pharmacy:

Name:_____
Street Address:_____
City, State_____
Phone Number_____

Child's current Weight_____ Current Height_____

Cerebral palsy	**Y N**	Hepatitis	**Y N**
Prenatal Hydronephrosis	**Y N**	Asthma	**Y N**
Heart Murmur	**Y N**	Constipation	**Y N**
Urinary Tract Infections	**Y N**	Hypertension	**Y N**
Developmental Delay	**Y N**	Spina Bifida	**Y N**
Seizure Disorder	**Y N**	VP Shunt	**Y N**
Bleeding Disorders	**Y N**	Premature	**Y N**
ADD/ADHD/Attention Deficit	**Y N**	Autism	**Y N**
Cancer **Y N** Type_____			

List any Allergies

Latex **Y N**

None: _____

Medication Allergies: _____

List any past Surgeries/Hospitalizations

Type	Date (Year only)

Family History

		Family Member			Family Member
Vesicoureteral Reflux	**Y N**	_____	Kidney Disease	**Y N**	_____
Nighttime Wetting	**Y N**	_____	Urinary Tract Infections	**Y N**	_____
Kidney Failure	**Y N**	_____	Diabetes	**Y N**	_____
Kidney Stones	**Y N**	_____	Cancer	**Y N**	_____
Anesthesia Problems	**Y N**	_____	Hypertension	**Y N**	_____

Social History

Special Diet? **Y N** Age of toilet training: _____

Special Needs (wheelchair, braces, etc.) **Y N** Who does child live with? _____

If patient is over 13 years of age, is there tobacco usage? Y N

PLEASE SEE OTHER SIDE

Does the patient now or in the past had any problems related to the following systems? (Circle Yes or No)

Constitutional Symptoms

Fever	**Y N**
Chills	**Y N**
Headache	**Y N**
Abnormal Development	**Y N**

Gastrointestinal

Abdominal Pain	**Y N**
Nausea/Vomiting	**Y N**
Stool Incontinence	**Y N**
Constipation	**Y N**
Blood in Stool	**Y N**

Respiratory (lungs)

Wheezing	**Y N**
Frequent Cough	**Y N**
Shortness of Breath	**Y N**

Eyes

Blurred Vision	**Y N**
Redness	**Y N**
Pain	**Y N**

Cardiovascular

Heart Murmur	**Y N**
High Blood Pressure	**Y N**

Hematologic/Lymphatic

Swollen Glands	**Y N**
Blood Clotting Problems	**Y N**

Allergic/Immunoligic

Hay Fever	**Y N**
Drug Allergies	**Y N**
Foods	**Y N**

Integumentary

Skin Rash	**Y N**
Persistent Itching	**Y N**
Easy Bruising	**Y N**

Endocrine

Excessive Thirst	**Y N**
Too Hot/Cold	**Y N**
Tired/Sluggish	**Y N**
Abnormal Hair Growth	**Y N**

Neurologic

Tremors	**Y N**
Coordination Problems	**Y N**
Abnormal Walk	**Y N**

Musculoskeletal

Joint Pain	**Y N**
Neck Pain	**Y N**
Back Pain	**Y N**

Ear/Nose/Throat/Mouth

Ear Infections	**Y N**
Sore Throat	**Y N**
Sinus Problems	**Y N**

Genitourinary

Painful Urination	**Y N**
Blood in Urine/Underwear	**Y N**
Urinary Retention	**Y N**
Frequent Urination	**Y N**
Urgency to Urinate	**Y N**
Daytime Wetting	**Y N**
Nighttime wetting	**Y N**

Does your child have any siblings?

Names	**Ages**

Has your child had any X-rays of the urinary tract or the current problem? (Test, Date, Hospital where performed)

TYPE	**DATE**	**HOSPITAL**

Does your child have any other medical Problems that we should know about? Y N **Please list below:**

_____

_____

_____

Physician's notes: _____

Physician's Signature: _____ **Date:** _____