

Date: _____

Chart #: _____

PATIENT HISTORY FORM - CHILD

Welcome to Urology Associates, P.C. This questionnaire is intended to be a COMPLETE account of your medical history. Please answer completely, including details and dates, if known. Incomplete answers to these questions could lead to improper treatment.

Patient Name: _____ **D.O.B:** _____ **Age:** _____

Who is your child's primary care doctor? _____

Why is your child seeing the doctor today? _____

Pharmacy Name, Address, Phone number _____

MEDICAL HISTORY Child's Height: _____ ft _____ in Weight: _____ lbs Temp: _____

Past Medical History (Circle yes or No)

Complications with pregnancy or delivery	Y	N	Pre-Maturity	Y	N	Urinary Tract Infections	Y	N
Abnormal prenatal ultrasounds or exams	Y	N	Unexplained Fevers	Y	N	Bedwetting	Y	N
Wets or Soils Underwear	Y	N	Persistent Constipation	Y	N	Known Medical Disease	Y	N
Heart Problems	Y	N	Lung Problems	Y	N	Intestinal Problems	Y	N
Nervous Disorder	Y	N						

PAST SURGICAL HISTORY (Please list any surgeries your child has had and approximate date):

ALLERGIES – Is your child allergic to: Latex Iodine Shellfish

MEDICATIONS THAT CAUSE ALLERGIES (i.e. hives, rash, difficulty breathing)

CURRENT MEDICATIONS _____ My Child currently take no medications.

List Medications with dose

1. _____ 2. _____ 3. _____

SOCIAL HISTORY

Does your child enjoy and participate normally in school or social activities? Y N If No, please explain:

FAMILY HISTORY

Birth Defects Y N Kidney, Bladder or Genital abnormalities Y N

Other _____

REVIEW OF SYSTEMS No symptoms at this time _____

Fever	Y	N	Swollen Glands	Y	N	Abdominal Pain	Y	N	Dizziness/Lightheadedness	Y	N
Fatigue	Y	N	Cough	Y	N	Nausea/Vomiting	Y	N	Depressed/Sad	Y	N
Rash/Itching	Y	N	Wheezing	Y	N	Blood in Urine	Y	N	Extreme sensitivity to cold/heat	Y	N
Headache	Y	N	Shortness of Breath	Y	N	Urinary Problems	Y	N	Bleed Easily	Y	N
Visual change	Y	N	Chest Pains	Y	N	Joint/Back Pains	Y	N			

Please elaborate on any "yes" answers from above (be as specific as possible): _____

(For Office Use Only)

ASSESSMENT OF PLAN

Flow Rate Bladder Scan UA w/micro Culture Cytology Renal U/S Pelvic U/S