NEW PATIENT HEALTH HISTORY
PEDIATRIC UROLOGY

Patient Name: ______________________________ **Date of Birth:** ____________ **Gender: M / F**

Person filling out form and relationship to patient: ______________________________

Please provide as much detail as you are able so that we can give you the safest and best care possible.

Preferred Pharmacy (name and location): ______________________________

Primary Care Provider

Name: ______________________________ Phone #: ____________

Address: ______________________________ Fax #: ____________

Reason for visit: ______________________________

When did this problem start? ______________________________

ALLERGIES

List any allergies and intolerances to medications, food or the environment (including latex or metal).

Allergy:	Reaction:

MEDICATIONS

List any medications your child is taking, with dose and how often. Include any vitamins, supplements and over the counter medicines.

Medication Name:	Dose:	How often?

Patient Medical History

List any current or past medical conditions (please place checkmark by any current problems).

❑ ______________________________

❑ ______________________________

❑ ______________________________

❑ ______________________________

❑ ______________________________

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(01/2017)

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Surgeries and/or Hospitalizations

Has your child been hospitalized or had any surgeries? Provide date and reason.

Date:	Reason:	Date:	Reason:

Has your child had any reactions to anesthesia? ❑ Yes ❑ No ❑ Has never had anesthesia If yes, explain: ____________

____

DIAGNOSTIC TESTS

List any X-Ray or ultrasound test your child has had recently along with the date and location.

Date	Location	Test

FAMILY HISTORY

List health conditions for each family member.

	Alive	Deceased	Age of Death	Health Condition(s)
Father				
Mother				
Brothers				
Sisters				
Paternal Grandmother				
Paternal Grandfather				
Maternal Grandmother				
Maternal Grandfather				

FAMILY HISTORY

Indicate which family member has the following medical history.

Yes / No		Family Member
	Cancer	
	Diabetes	
	Kidney disease	
	Kidney failure	
	Kidney stones	
	Night time wetting	
	Problems with Anesthesia	
	Urinary tract infection	
	Vesicoureteral reflux	

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NEW PATIENT HEALTH HISTORY
PEDIATRIC UROLOGY

Dental History

(For 12 months and older)

Name of your child's dentist and date of last visit: ____________________

Does your child need preventative antibiotics for dental or other procedures? Yes / No

SOCIAL HISTORY

Patient lives with (please indicate all)

❑ Mother ❑ Father ❑ Step-Father ❑ Step-Mother

❑ Other (Please Specify) ____________________ Relationship ____________________

Toilet trained at age: ____________________

Type of diet: ____________________

Other

Is there anything else you would like to tell us or we should know about? ____________________

____

____

What three questions would you like answered or addressed today?

1. ____________________

   ____

2. ____________________

   ____

3. ____________________

   ____

Review of Systems

Does the patient currently have or in the past had problems related to the following:

Weight gain	**Y / N**	Chest pain	**Y / N**	Scrotum testicular mass	**Y / N**	Skin itching	**Y / N**
Weight loss	**Y / N**	Fainting	**Y / N**	Painful bleeding	**Y / N**	Skin lesion	**Y / N**
Chills	**Y / N**	Diarrhea	**Y / N**	Heavy menstrual bleeding	**Y / N**	Bone pain	**Y / N**
Dizzy	**Y / N**	Heartburn	**Y / N**	Excessive Thirst	**Y / N**	Joint pain	**Y / N**
Trouble swallowing	**Y / N**	Vomiting	**Y / N**	Frequent urination	**Y / N**	Joint swelling	**Y / N**
Vision loss	**Y / N**	Runny nose	**Y / N**	Scrotum testicular mass	**Y / N**	Swollen lymph nodes	**Y / N**
Shortness of breath	**Y / N**	Allergic rash	**Y / N**	Distorted body image	**Y / N**	Red spots	**Y / N**
Known TB exposure	**Y / N**	Penile discharge	**Y / N**	Self-conscious	**Y / N**	Bleeding disorders	**Y / N**

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