



Patient Label

Patient Medical History - Pediatric

Height _____ Weight _____

Describe the location / symptom / problem that is the reason for your visit: _____

Who referred you for this consultation? (Self? Doctor? If so, from what clinic?) _____

Circle the severity number of the problem on a scale of 1-10: (1=low) 1 2 3 4 5 6 7 8 9 10 (10=high)

History of Present Illness

How long has your child had this problem? _____

What have you done to solve the problem? _____

Have you seen a urologist? No Yes If yes, name of urologist _____

How was the problem treated? _____ Better? Worse?

Has your child ever had a urinary tract infection? No Yes

- If yes, was it with a fever? No Yes How high was the fever? _____

Physician Comments:

Complete this section if your child is potty trained or has attempted potty training

At what age was potty training first attempted? _____

Is your child potty trained? No Yes

- If yes, at what age? _____
- If yes, was potty training easy difficult normal

Does your child wet their pants during the day? No Yes

- If yes, constantly? _____ Times a day _____ Times a week _____ Times a month _____

Does your child wet the bed? No Yes

- If yes, nightly? _____ Times per week _____ Times per month _____

Have you tried to treat the wetting problem? How? _____

What has been your child's longest dry period? (e.g. 1 month, 6 months, never) _____

***How many times a day does your child urinate in a typical day? _____

*** (Important information. Please review with your child and fill in the answer as accurately as possible.)

Does your child have any of the following symptoms during urination?

- Burning Strains to start or maintain a stream Blood in urine
- Urgency Frequency (urinates more than every hour)

Does your child ever complain of lower abdominal pressure while voiding? No Yes

Bowel Habits

How often does your child have a bowel movement? _____x week. Is your child ever constipated? No Yes

Does your child have fecal soiling in their underwear, more than just poor wiping? No Yes

Are your child's bowel movements excessively large? No Yes

Are your child's bowel movements excessively hard? No Yes

Does your child have frequent stomachaches? No Yes

- If yes, how often? _____

PAST MEDICAL AND FAMILY HISTORY

Does your child or a blood **relative** have problems (now or in the past) with any of the following?

No Yes

If yes, **please check** all boxes that apply.

	Patient	Family Member
Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Type: _____		
Depression	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
GERD / Acid Reflux	<input type="checkbox"/>	<input type="checkbox"/>
Gout (high uric acid)	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>
Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>
Toxic Exposure	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Other/Explain:	<input type="checkbox"/>	<input type="checkbox"/>

Did your child have **surgery** on any of the following? No Yes

If yes, **please check** all boxes that apply.

Appendix	<input type="checkbox"/>
Back	<input type="checkbox"/>
Bladder	<input type="checkbox"/>
Breast	<input type="checkbox"/>
Colon	<input type="checkbox"/>
Gallbladder	<input type="checkbox"/>
Heart Valve	<input type="checkbox"/>
Hernia	<input type="checkbox"/>
Incontinence	<input type="checkbox"/>
Kidney	<input type="checkbox"/>
Lung	<input type="checkbox"/>
Testicle	<input type="checkbox"/>
Thyroid	<input type="checkbox"/>
Urethra	<input type="checkbox"/>
Other/Explain:	<input type="checkbox"/>

Have you ever had MRSA? No Yes

Positive Mantoux/PPD? No Yes

Latex allergy? No Yes

Does your child have any allergies to food and medications? No Yes

If yes, please list the allergy and type of reaction:

List any hospitalizations your child has had and when they occurred:

List all of your child's current **medications** and their dosages: _____

Social History

List names and ages of patient's siblings _____

Patient attends: daycare preschool school home school none

Current grade in school _____

REVIEW OF SYSTEMS

Please circle No or Yes if your child has had any of the following in the past month.

Constitutional Symptoms

Weight loss No Yes
Fatigue No Yes
Fever No Yes
Chills No Yes
Other_____ No Yes

Musculoskeletal

Joint problems No Yes
Back problems No Yes
Difficulty moving arms
and legs: No Yes
Other_____ No Yes

Hematological/Lymphatic

Enlarged lymph nodes:
No Yes
Anemia No Yes
Leukemia No Yes
Lymphoma No Yes
Other_____ No Yes

Ear/Nose/Throat/Mouth

Ear infections No Yes
Sinus problems No Yes
Sore throat No Yes
Other_____ No Yes

Integumentary

Skin rashes No Yes
Skin sores No Yes
Mole changes No Yes
Other_____ No Yes

Immunologic

Immunodeficiency:
No Yes
Organ transplant recipient:
No Yes
HIV No Yes
Other_____ No Yes

Cardiovascular

Heart murmur No Yes
Cardiac defects No Yes
Other_____ No Yes

Neurological

Headaches No Yes
Seizures No Yes
Dizziness No Yes
Fainting No Yes
Numbness No Yes
Tingling No Yes
Other_____ No Yes

Eyes

Blurred vision No Yes
Double vision No Yes
Pain No Yes
Other_____ No Yes

Respiratory

Asthma No Yes
Colds No Yes
RSV No Yes
Coughing No Yes
Wheezing No Yes
Other_____ No Yes

Psychiatric

Depression No Yes
Stress No Yes
Anxiety No Yes
Anorexia No Yes
Bulimia No Yes
Other_____ No Yes

Genitourinary

Urine retention No Yes
Painful urination No Yes
Urinary No Yes
frequency
Other _____ No Yes

Gastrointestinal

Constipation No Yes
Diarrhea No Yes
Vomiting No Yes
Reflux No Yes
Stomach Pains:
No Yes
Other_____ No Yes

Endocrine

Excessive thirst No Yes
Diabetes No Yes
Growth problem No Yes
Other_____ No Yes

Allergy

Hay fever No Yes
Drug allergies No Yes
Other _____ No Yes

Urologist use only:

Present Illness

Vitals: Wt _____ Temp _____
BP _____ Pulse _____

General
Skin
Neck
Respiratory
Abdomen
Back
Genitalia
Lower extremity

Imaging

Problem

Plan

V	<u>Urinalysis</u>	C
old-fresh		
Sp. Gr _____	_____	WBC
PH _____	_____	RBC
Sugar _____	_____	Bacteria
Alb _____	_____	Crystals
Hb _____	_____	Epith
LF/KZ 7/12/07	_____	Mucus
	_____	Casts
	_____	Other

M.D.

Signature