Children's Urology Group

ACCT# _____

PATIENT: _____

DOB: _____ AGE: _____ MALE _____ FEMALE _____

DATE: _____ LOCATION: _____

NEW PATIENT HISTORY QUESTIONNAIRE

Primary Care Physician _____

Requesting Physician _____

Reason for Consultation _____

SOURCE OF INFORMATION

Person Providing Information _____

Relationship to Patient _____

Language Spoken _____

CHIEF COMPLAINT: _____ **Symptoms for how long?** _____

HISTORY OF PRESENT ILLNESS

Is there pain or burning?	No	Yes	Does the patient wet the bed?	No	Yes
Is there blood in urine?	No	Yes	Is the patient toilet trained?	No	Yes
Has patient had fever with these symptoms?	No	Yes	Has patient had constipation problems?	No	Yes
Are symptoms getting worse?	No	Yes	Any previous treatment or antibiotics?	No	Yes

If yes, describe _____

PAST MEDICAL HISTORY

Was birth normal full term? No Yes If not, how early? _____

Any Complications or chronic conditions impacting the patient's health? No Yes If yes, (circle)

Other conditions? _____

Asthma Cerebral Palsy Heart Problems

_____

Hydrocephalus Muscular Dystrophy Spina Bifida

Has the patient ever been hospitalized? No Yes List when, where & reason: _____

Has the patient ever had any operations? No Yes List when, where & reason: _____

Is patient ALLERGIC to anything? No Yes If yes, please list along with reactions: _____

MEDICATIONS: Is patient taking any medication – prescribed or over the counter including Tylenol / Vitamins? No Yes If yes, please list along with dose and times per day: _____

FAMILY HISTORY

Do any family members have urologic problems, kidney disease or a diagnosis of bedwetting? No Yes

If yes, which family member(s)? (Circle all that apply)

Father Mother Brother Sister Half sister
Grandfather Grandfather Half brother
Grandmother Grandmother
Uncle / Aunt Uncle / Aunt

Medical History not available (Adopted/other) No Yes

SOCIAL HISTORY

Are there Smokers in Household? No Yes

Patient lives with: Mom Dad Grandparents Sister Brother Aunt Uncle Other _____
Guardian Foster

Are the parents: Married Separated Divorced Single parent family

ETHNICITY: (AM) (CAN) (HISPANIC) (NON-HISPANIC)
(LATINO) (NON-MEXICAN) (UNKNOWN)

RACE: (Am Indian) (AK Native) (Asian) (Black Hispanic) (Black African-AM)
(Native Hawaiian/Pacific Island) (Other) (Unknown) (White) (White Hispanic)

REVIEW OF SYSTEMS

Cons: Fevers or weight loss	No	Yes	ENDO: Thyroid or diabetes problems	No	Yes
Eyes: Vision problems	No	Yes	HEM/LYMPH: Bleeding problems	No	Yes
ENT: Sinus or ear infections	No	Yes	ALL/IMMUNE: Allergies or frequent infections	No	Yes
C/V: Heart problems	No	Yes	NEURO: Seizures or brain problems	No	Yes
RESP: Breathing, snoring or sleep problems	No	Yes	PSYCH: Development / Learning problems	No	Yes
Skin: Rashes	No	Yes	GI: Stomach or bowel problems	No	Yes
Musc: Bone or muscle problems	No	Yes	GU: Bladder or kidney problems	No	Yes

FAMILY COMMENTS:

_____

_____

STAFF NOTES:

_____

_____

_____ _____
Staff Signature/Title **Date/Time**

_____ _____
Parent/Guardian Signature: **Date/Time**

_____ _____
Translator Name/Signature **Date/Time**

I have reviewed the above information

_____ _____
Attending Signature/Title **Date/Time**