PediatricUrology
ASSOCIATES

Child History Form

Last Name: _____ **First Name:** _____ **Date of Birth:** _____

Medications (Currently Taking)

Name	Amount	Time/Day

Current weight: _____

List any Allergies

Latex	Yes	No
Medications:		**Reaction:**

Family History

			Family Member
Anesthesia Problems	Y	N	
Bleeding Disorder	Y	N	
Kidney Disease	Y	N	
Kidney Failure	Y	N	
Kidney Stones	Y	N	
Nighttime wetting	Y	N	
Urinary Tract Infection	Y	N	
Vesicoureteral Reflux	Y	N	

Child Medical History

Asthma	Yes	No
Bleeding Disorder	Yes	No
Cancer	Yes	No
Cerebral Palsy	Yes	No
Developmental Delay	Yes	No
Heart Disease	Yes	No
Prenatal Hydroneprosis	Yes	No
Seizure Disorder	Yes	No
Spinal Bifida	Yes	No
VP Shunt	Yes	No

Past Surgeries/Hospitalizations

Type	Year

Social History

Age of Toliet training	_____	
Special Diet	Yes	No
Special Needs	Yes	No
Wheelchair/ Brace		
Tobacco Exposure	Yes	No
Who does child live with:		

Does your child have siblings?

Names	Age

Entered in EPIC by: _____

Please Answer Yes or No

Constitutional Symptoms

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

Eyes

Blurred Vision	Y	N
Redness	Y	N
Pain	Y	N

Allergic/Immunologic

Hay Fever	Y	N
Drug Allergies	Y	N
Food	Y	N

Neurologic

Tremors	Y	N
Coordination Problems	Y	N
Abnormal Walk	Y	N

Ear/Nose/Throat/Mouth

Ear Infection	Y	N
Sore Throat	Y	N
Sinus Problem	Y	N

Gastrointestinal

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

Cardiovascular

Heart Murmur	Y	N
High Blood Pressure	Y	N

Integumentary

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

Musculoskeletal

Joint Pain	Y	N
Neck Pain	Y	N
Back Pain	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

Respiratory (Lungs)

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

Hematologic/Lymphatic

Swollen Glands	Y	N
Blood Clotting Problem:	Y	N

Endocrine

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

Does your child have any other Medical Problems we should know about?
Please List:

_____

_____

_____

_____

_____

_____

Physcian: _____ Date: _____

Health Insurance Portability and Accountability Act

(HIPAA)

Patient's Name: _____ Date of Birth _____/_____/_____

We are required by law to provide you with our Notice of Privacy Practices which explain how we use and disclose your health information. We are also required to obtain your signature acknowledging that this notice has been made available to you.

Signature _____ **Date:** _____

Relationship to Patient: Self Parent Spouse Other _____

Reason Patient unable/Unwilling to sign:

_____

_____