Northwest Urology LLC

Pediatric Medical History for Date: _____

Patient Name: _____ Date of Birth: _____

Reason for today's visit: _____

_____

_____

_____

Urological Problems (Please circle answer. If **Y**es, please explain):

Bladder/Kidney/Urinary Tract Infections	N Y _____		How often: _____	
Was there a fever with the infection?	N Y _____		Highest temp: _____	
Pain when urinating?	N	Rarely	Occasionally	Frequently
Penile Infections?	N N/A	Rarely	Occasionally	Frequently
Blood in Urine?	N Y (on a urine test)		Y (visible)	
Toilet Trained?	N Y		What age: _____	
Daytime Urine Leakage?	N	Rarely	Occasionally	Frequently
Get up at night to urinate?	Never	Rarely	Occasionally	Frequently
Bed Wetting?	Never	Rarely	Occasionally	Frequently
Sudden urge to urinate?	N	Rarely	Occasionally	Frequently

How often during the day does he/she urinate?: _____

MEDICATIONS and **DOSAGES**:

_____

_____

ALLERGIES (dietary, medications, other): NO YES:

_____

_____

Past Medical History (Please circle all that apply):

Eyes:	Glaucoma		Other: _____
Neurological:	Seizures	ADD/Hyperactivity	Other: _____
Endocrine (Gland):	Diabetes	Adrenal Disease	Other: _____
Pulmonary (Breathing):	Asthma/Wheezing	Pneumonia	Other: _____
Cardiac (Heart):	High Blood Pressure	Congenital Heart Disease	Other: _____
Gastrointestinal:	Crohn's/UC	GE Reflux	Other: _____
Infections:	Hepatitis	Tuberculosis (TB)	Other: _____

Syndromes/Chromosomal/OTHER problems: _____

Are immunizations up to date? No Yes

Baby born at: _____ weeks **(40 is normal)** **Birth Weight:** _____

Did Mother have problems during pregnancy? No Yes: _____

Drugs or medications taken during pregnancy: _____

Problems at birth?_____

(continued on back)

Surgeries and Dates: _____
Hospitalizations and Dates: _____
Menstruation History: N/A Age of onset: _____ **Date of last period:** _____

Child lives: At Home Foster Home Facility: _____
Child lives with: Mother Father Guardian/Relative Siblings/Other Children: _____
Does child attend school? No Yes **If yes, what time does child get home?**_____

FAMILY Medical Problems (circle)? **Kidney Failure; Urine infection in children; Bleeding disorder; Kidney, Bladder, Genital Abnormalities in Children**

Other: _____

Are you **CURRENTLY** experiencing any of the following:

Constitutional Problems:
- Fevers/Chills No Yes
- Headaches No Yes
- Other: _____

Eye Problems:
- Needs glasses/contacts No Yes
- Blurry vision No Yes
- Other: _____

ENT Problems:
- Congestion/Sinus trouble No Yes
- Recurrent ear infections No Yes
- Sore throat No Yes
- Other: _____

Cardiac (Heart) Problems:
- Turning blue No Yes
- Irregular heartbeat No Yes
- Heart murmur No Yes
- Other: _____

Pulmonary (Breathing/Respiratory) Problems:
- Wheezing No Yes
- Chronic cough No Yes
- Other: _____

GI (Gastrointestinal) Problems:
- Constipation No Yes
- Diarrhea No Yes
- Nausea/Vomiting No Yes
- Abdominal Pain No Yes
- Other: _____

Muscle/Joint Problems:
- Chronic back pain No Yes
- Chronic leg pain No Yes
- Lower extremity coordination concerns No Yes
- Other: _____

Skin Problems:
- Frequent rashes No Yes
- Other: _____

Neurological Problems:
- Learning problems No Yes
- Seizures No Yes
- Developmental delay No Yes
- Other: _____

Psychological Problems:
- Depression No Yes
- Anxiety No Yes
- Other: _____

Endocrine (Gland) Problems:
- Excessive thirst No Yes
- Too hot/cold No Yes
- Other: _____

Heme/Lymph Problems:
- Swollen glands No Yes
- Blood transfusion No Yes
- Clotting problems No Yes
- Other: _____

Genitourinary Problems:
- Incontinence No Yes
- Painful urination No Yes
- Blood in urine No Yes
- Other: _____