CHILD'S HISTORY FORM

Date ____/ ____/ ____

CHILD'S NAME: ___________________________________DATE OF BIRTH_______AGE______
CHILD'S REGULAR DOCTOR: _____________________________
CHIEF COMPLAINT:
What is the main reason for your visit to the urologist today?

How long has this been a problem?

HISTORY OF PRESENT ILLNESS
Does your child have or has he/she recently had any of the following listed below? Please circle your response

- Blood in urine?...YES NO
- Weak, dribbling stream or trouble starting a stream (poor force)..YES NO
- Urinating more frequently than usual? If yes how often _____.......................... YES NO
- Awakening frequently at night to urinate? If yes how often_____.................. ..... YES NO
- Wetting the bed at night?... YES NO
- Daytime wetting of clothes?... .YES NO
- Burning or Pain with urination?.. YES NO
- Back Pains?... YES NO
- Abdominal Pains?.. YES NO
- Leakage of urine when coughing, straining, sneezing or exercising.......................... . YES NO
- Leakage of urine if he /she doesn't get to the restroom immediately?............ YES NO
- Urinary tract infections?.. YES NO
- Skin Problems in the Genital or groin area?... YES NO
- Ever had x-rays (IVP or ultrasound) performed?... .YES NO

PAST MEDICAL AND SURGICAL HISTORY

- Serious Medical Illnesses (check all that apply)

_____ Heart Problems
_____ Lung (breathing problems)
_____ Cancer
_____Kidney disease
_____ Arthritis
_____ Bleeding Problems
_____Diabetes
_____ Frequent infections
_____ Neurological and Developmental Problems

- Is your child presently under the care of a doctor for any chronic medical or surgical problems? ___Yes __No
- Is your child up to date on childhood Immunizations? ____ Yes ____ No
- Previous Major Surgeries and Hospitalizations (Please List)

Date	Type / Reason	Surgeon/ Physician	Hospital

BIRTH, DEVELOPMENTAL AND SOCIAL HISTORY

- Were there any complications during the pregnancy or birth of you child? ____ Yes ____No
  If Yes, Briefly Explain____
- What was your child's birth weight? ______________________
- To date has your child attained age appropriate developmental milestones such as crawling, walking, talking, feeding and dressing self? ____ Yes ____ No
- Is your child in school or daycare? ____ Yes ____ No
- How many siblings does your child have? _____
- Is your child exposed to cigarette smoke? ____Yes ____ No

MEDICATIONS

Please list all prescription and over-the-counter medications, including vitamins and herbs that your child is taking.

______________ ______________ ______________ ______________

______________ ______________ ______________ ______________

______________ ______________ ______________ ______________

ALLERGIES TO MEDICATIONS

______ No Known Drug Allergies

______________ ______________ Has your child had a reaction to iodine x-ray dye? ____Yes ___No

______________ ______________ If yes, what type of reaction? _________________________________

FAMILY HISTORY (Check all that apply)

____ Heart disease ____ Diabetes ____ Lung Disease ____ Arthritis

____ High Blood Pressure ____ Cancer ____ Strokes ____ Tuberculosis

____ Kidney disease Or Stones ____ Neurological Problems

Review of Systems

Does your child now or has he/she had any recent problems related to the following system? Circle Yes or No
Please explain any yes answer in space provided

General
- Fever Y N
- Chills Y N
- Abnormal growth Y N
- Abnormal development Y N
- Other___________________________

Eyes
- Blurred vision Y N
- Redness Y N
- Pain Y N
- Other_________________________

Allergies
- Hay fever Y N
- Drug allergies Y N
- Foods Y N
- Other__________________________

Nervous system
- Seizures Y N
- Abnormal walking Y N
- Abnormal coordination Y N
- Other__________________________

Hormone system
- Excessive thirst Y N
- Tired/sluggish Y N
- Abnormal hair growth Y N
- Other_________________________

Stomach/intestines
- Stomach pain Y N
- Nausea/ vomiting Y N
- Constipation Y N
- Other__________________________

Heart
- Heart murmur Y N
- High blood pressure Y N
- Other__________________________

Skin
- Rashes Y N
- Continued Itching Y N
- Easy bruising Y N
- Other_____________________________

Muscle system
- Joint pain Y N
- Back pain Y N
- Muscle Cramping Y N
- Other___________________________

Ear/ Nose/ Throat/ Mouth
- Ear infections Y N
- Sore throat Y N
- Sinus problems Y N
- Other__________________________

Kidney / Bladder
- Blood in urine Y N
- Burning with urination Y N
- Frequent urination Y N
- Other_________________________

Lungs
- Wheezing Y N
- Frequent cough Y N
- Shortness of breath Y N
- Other__________________________

Blood/ Lymph glands
- Swollen glands Y N
- Blood clotting problems Y N
- Other_________________________

____

Physicians Use Only: (comments)

#= L 0-1= 1-2 2-9= 3 > 10= 4-5

Physicians___________________________________ **Date** ___/ ___/ ___