

PATIENT NAME: _____ **DATE:** ___/___/___ **MED REC #:** _____
DATE OF BIRTH: ___/___/___ **AGE:** _____ **HEIGHT:** _____ **FT** _____ **IN** **WEIGHT:** _____ **LBS**
 Name of Referring Physician: _____ Referring Physician's Fax#: _____
 Referring Physician's Address: _____
 Race: Caucasian African American Hispanic/Latino Asian Other: _____ Sex: Female Male

Reason for your visit today: _____

Drug Allergies: _____

Other Allergies: _____

Preferred Pharmacy: _____ **Pho #:** _____ **Fax#:** _____

CURRENT MEDICATIONS: Please list any prescription medications, over-the-counter medications and vitamin supplements you take routinely---(PLEASE BRING BOTTLES OF *NONREFRIGERATED* MEDICATIONS WITH YOU TO YOUR APPOINTMENT):

Name of Drug or Supplement:	Strength (mg):	How often (# of times per day)

MEDICAL HISTORY: Please check any of the following conditions which **YOU** have had or presently have:

- | | | |
|--|---|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Neurologic Disease | <input type="checkbox"/> Syndrome: _____ |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Prematurity | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Cardiac Disorder | <input type="checkbox"/> Renal/Kidney Disease | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> GERD/Reflux | <input type="checkbox"/> Respiratory Disorder | |

SURGICAL HISTORY: Please check any of the following procedures you have had performed and the date of the procedure

	Yr		Yr	Females Only		Males Only	
<input type="checkbox"/> Appendicovesicostomy		<input type="checkbox"/> Pyeloplasty		<input type="checkbox"/> Genital Surgery	Yr		Yr
<input type="checkbox"/> Bladder Augmentation		<input type="checkbox"/> Ureteral deflux		<input type="checkbox"/> Intersex repair		<input type="checkbox"/> Circumcision	
<input type="checkbox"/> Bladder neck deflux		<input type="checkbox"/> Ureteral stents placed		<input type="checkbox"/> Lysis Labial adhesions		<input type="checkbox"/> Hernia repair	
<input type="checkbox"/> Bladder diverticulectomy		<input type="checkbox"/> Ureteral reimplant				<input type="checkbox"/> Hydrocelectomy	
<input type="checkbox"/> Bladder neck Sling		<input type="checkbox"/> Ureterocelelectomy				<input type="checkbox"/> Hypospadias	
<input type="checkbox"/> Cysto		<input type="checkbox"/> Ureteroureterostomy				<input type="checkbox"/> Meatoplasty	
<input type="checkbox"/> ESWL						<input type="checkbox"/> Orchiectomy	
<input type="checkbox"/> Kidney Removed		Other:				<input type="checkbox"/> Orchiopexy	
<input type="checkbox"/> Partial kidney removed		<input type="checkbox"/>				<input type="checkbox"/> Varicocelelectomy	
<input type="checkbox"/> Kidney stone surgery		<input type="checkbox"/>		Other:		Other:	
<input type="checkbox"/> Perc stone removal		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	

CHRONIC PROBLEMS LIST: Please list any **chronic** health problems you have

Problem: _____	Date of onset: _____	Treatment: _____
Problem: _____	Date of onset: _____	Treatment: _____
Problem: _____	Date of onset: _____	Treatment: _____

WETTING, URINARY INFECTIONS OR REFLUX: Please complete the following section-Mark any that apply to the patient

Bladder:

- Frequent Urination
- Daytime accidents-#per day _____
- Nighttime accidents-# per night _____
- # of times child empties bladder per day-_____
- Holds or postpones going to bathroom
- Races to go to the bathroom
- Age when potty trained (daytime)-_____
- Cannot feel the need to urinate
- Sits on heel to hold urine

Bowel:

- Constipation, if so, # of stools per week-_____
- Stool soiling
- Pain with stools
- Blood on stools
- Stool stops up toilet
- Diarrhea
- Frequent tummy aches

FAMILY HISTORY: Please check any of the following conditions that apply to your family members and list their relation to you:

Diagnosis:	Yes	No	Relationship:	Diagnosis:	Yes	No	Relationship
Bleeding disorder				Renal Failure			
Cardiac abnormalities				Undescended testis			
Hematuria (blood in urine)				Urinary incontinence-daytime			
Hypospadias				Urinary incontinence-night			
Kidney stones				Urinary obstruction/blockage			
Kidney surgery				Urinary tract infections			
Prenatal abnormalities				Urinary reflux			
Problems with surgery							
Problems with anesthesia							
Other:				Other:			

Family Status:

Parent Status: Single Married Divorced Widowed Number of Brothers:_____ Number of Sisters:_____

Custodial Parent: Mother Father Shared Foster Parents Grandparent Other:_____

CAFFEINE: Yes No Type:_____ Amount daily:_____

LIFESTYLE:

Hobbies: _____

Exercise? Yes No If yes, Type:_____ Frequency:_____ per _____ Hours per week: _____

REVIEW OF SYSTEMS: Within the last 3 months have you had any of the following? (Please mark all yes or no):

<div style="border: 1px solid black; padding: 2px; margin-bottom: 5px;">Constitutional--<input type="checkbox"/>Neg</div> No Yes <input type="radio"/> <input type="radio"/> chills <input type="radio"/> <input type="radio"/> fever <input type="radio"/> <input type="radio"/> night sweats	<div style="border: 1px solid black; padding: 2px; margin-bottom: 5px;">Cardiovascular--<input type="checkbox"/>Neg</div> No Yes <input type="radio"/> <input type="radio"/> chest pain <input type="radio"/> <input type="radio"/> palpitations <input type="radio"/> <input type="radio"/> shortness of breath with exertion <input type="radio"/> <input type="radio"/> murmur	<div style="border: 1px solid black; padding: 2px; margin-bottom: 5px;">Genitourinary--<input type="checkbox"/>Neg</div> No Yes <input type="radio"/> <input type="radio"/> painful urination <input type="radio"/> <input type="radio"/> blood in urine <input type="radio"/> <input type="radio"/> urinary frequency <input type="radio"/> <input type="radio"/> urinary retention <input type="radio"/> <input type="radio"/> urinary urgency <input type="radio"/> <input type="radio"/> urethral discharge	<div style="border: 1px solid black; padding: 2px; margin-bottom: 5px;">Immunologic--<input type="checkbox"/>Neg</div> No Yes <input type="radio"/> <input type="radio"/> food allergies	
<div style="border: 1px solid black; padding: 2px; margin-bottom: 5px;">Ears,Nose,Throat, Mouth--<input type="checkbox"/>Neg</div> No Yes <input type="radio"/> <input type="radio"/> blurred vision <input type="radio"/> <input type="radio"/> trouble swallowing <input type="radio"/> <input type="radio"/> nose bleeds <input type="radio"/> <input type="radio"/> runny nose <input type="radio"/> <input type="radio"/> ear infections	<div style="border: 1px solid black; padding: 2px; margin-bottom: 5px;">Gastrointestinal--<input type="checkbox"/>Neg</div> No Yes <input type="radio"/> <input type="radio"/> abdominal pain <input type="radio"/> <input type="radio"/> blood in stool <input type="radio"/> <input type="radio"/> colic <input type="radio"/> <input type="radio"/> constipation <input type="radio"/> <input type="radio"/> diarrhea <input type="radio"/> <input type="radio"/> loss of appetite <input type="radio"/> <input type="radio"/> nausea <input type="radio"/> <input type="radio"/> vomiting	<div style="border: 1px solid black; padding: 2px; margin-bottom: 5px;">Psychiatric--<input type="checkbox"/>Neg</div> No Yes <input type="radio"/> <input type="radio"/> anxiety <input type="radio"/> <input type="radio"/> depression <input type="radio"/> <input type="radio"/> insomnia	<div style="border: 1px solid black; padding: 2px; margin-bottom: 5px;">Musculoskeletal<input type="checkbox"/>Neg</div> No Yes <input type="radio"/> <input type="radio"/> arthritis <input type="radio"/> <input type="radio"/> back pain <input type="radio"/> <input type="radio"/> joint pain <input type="radio"/> <input type="radio"/> neck pain <input type="radio"/> <input type="radio"/> decreased muscle tone <input type="radio"/> <input type="radio"/> special needs (brace, wheelchair, etc)	
<div style="border: 1px solid black; padding: 2px; margin-bottom: 5px;">Respiratory--<input type="checkbox"/>Neg</div> No Yes <input type="radio"/> <input type="radio"/> chronic cough <input type="radio"/> <input type="radio"/> shortness of breath <input type="radio"/> <input type="radio"/> wheezing <input type="radio"/> <input type="radio"/> history of RSV <input type="radio"/> <input type="radio"/> history of asthma <input type="radio"/> <input type="radio"/> history of reactive airway disease	<div style="border: 1px solid black; padding: 2px; margin-bottom: 5px;">Integumentary--<input type="checkbox"/>Neg</div> No Yes <input type="radio"/> <input type="radio"/> contact allergy <input type="radio"/> <input type="radio"/> hives <input type="radio"/> <input type="radio"/> itching skin <input type="radio"/> <input type="radio"/> rash <input type="radio"/> <input type="radio"/> eczema	<div style="border: 1px solid black; padding: 2px; margin-bottom: 5px;">Endocrine---<input type="checkbox"/>Neg</div> No Yes <input type="radio"/> <input type="radio"/> excessive thirst <input type="radio"/> <input type="radio"/> fatigue	<div style="border: 1px solid black; padding: 2px; margin-bottom: 5px;">Hema/Lymphatic<input type="checkbox"/>Neg</div> No Yes <input type="radio"/> <input type="radio"/> easy bleeding <input type="radio"/> <input type="radio"/> enlarged lymph nodes <input type="radio"/> <input type="radio"/> easy bruising	
				<div style="border: 1px solid black; padding: 2px; margin-bottom: 5px;">Neurological--<input type="checkbox"/>Neg</div> No Yes <input type="radio"/> <input type="radio"/> difficulty walking <input type="radio"/> <input type="radio"/> headache <input type="radio"/> <input type="radio"/> dizziness <input type="radio"/> <input type="radio"/> seizure disorder <input type="radio"/> <input type="radio"/> difficulty with coordination

All Negative