Urology Clinics of North Texas
PEDIATRIC HEALTH HISTORY FORM

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 visit today: ______________________
Drug Allergies: ______________________
Other Allergies:______________________
Preferred Pharmacy: ______________________ **Pho #:**______________________ **Fax#:**___________________
CURRENT MEDICATIONS: Please list any prescription medications, over-the-counter medications and vitamin supplements taken routinely---(PLEASE BRING BOTTLES OF *NONREFRIGERATED* MEDICATIONS WITH YOU TO THE APPOINTMENT):

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

MEDICAL HISTORY OF PATIENT: Please check any of the following conditions which **THE PATIENT** has had or presently has:

❒Asthma
❒Bleeding Disorder
❒Cardiac Disorder
❒GERD/Reflux
❒Neurologic Disease
❒Prematurity **(_____ wks)**
❒Renal/Kidney Disease
❒Respiratory Disorder
❒Syndrome:_____________________________________
❒Other:____
❒Other:____

SURGICAL HISTORY OF PATIENT: Please √ any of the following procedures performed on patient & the date of the procedure

	Yr		Yr	Females Only	Yr	Males Only	Yr
❒Appendicovesicostomy		❒Pyeloplasty		❒Genitial Surgery	Yr		Yr
❒Bladder Augmentation		❒Ureteral deflux		❒Intersex repair		❒Circumcision	
❒Bladder neck deflux		❒Ureteral stents placed		❒Lysis Labial adhesions		❒Hernia repair	
❒Bladder diverticulectomy		❒Ureteral reimplant				❒Hydrocelectomy	
❒Bladder neck Sling		❒Ureterocelectomy				❒Hypospadias	
❒Cysto		❒Ureteroureterostomy				❒Meatoplasty	
❒ESWL						❒Orchiectomy	
❒Kidney Removed		**Other:**				❒Orchiopexy	
❒Partial kidney removed		❒				❒Varicocelectomy	
❒Kidney stone surgery		❒		**Other:**		**Other:**	
❒Perc stone removal		❒		❒		❒	
		❒		❒		❒	

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 _________ # per week ________
❒Nighttime accidents-# per week________
❒# 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 **family members**:

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 if not married: ❍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, has **patient** had any of the following? (Please mark all yes or no):

❒ **No change in illness/es since last visit**

Constitutional--❒Neg

No Yes
- ❍ ❍ chills
- ❍ ❍ fever
- ❍ ❍ night sweats

Ears,Nose,Throat, Mouth-❒Neg

No Yes
- ❍ ❍ blurred vision
- ❍ ❍ trouble swallowing
- ❍ ❍ nose bleeds
- ❍ ❍ runny nose
- ❍ ❍ ear infections

Respiratory--❒Neg

No Yes
- ❍ ❍ chronic cough
- ❍ ❍ shortness of breath
- ❍ ❍ wheezing
- ❍ ❍ history of RSV
- ❍ ❍ history of asthma
- ❍ ❍ history of reactive airway disease

Cardiovascular--❒Neg

No Yes
- ❍ ❍ chest pain
- ❍ ❍ palpitations
- ❍ ❍ shortness of breath with exertion
- ❍ ❍ murmur

Gastrointestinal-❒Neg

No Yes
- ❍ ❍ abdominal pain
- ❍ ❍ blood in stool
- ❍ ❍ colic
- ❍ ❍ constipation
- ❍ ❍ diarrhea
- ❍ ❍ loss of appetite
- ❍ ❍ nausea
- ❍ ❍ vomiting

Integumentary--❒Neg

No Yes
- ❍ ❍ contact allergy
- ❍ ❍ hives
- ❍ ❍ itching skin
- ❍ ❍ rash
- ❍ ❍ eczema

Genitourinary--❒Neg

No Yes
- ❍ ❍ painful urination
- ❍ ❍ blood in urine
- ❍ ❍ urinary frequency
- ❍ ❍ urinary retention
- ❍ ❍ urinary urgency
- ❍ ❍ urethral discharge

Psychiatric--❒Neg

No Yes
- ❍ ❍ anxiety
- ❍ ❍ depression
- ❍ ❍ insomnia

Endocrine---❒Neg

No Yes
- ❍ ❍ excessive thirst
- ❍ ❍ fatigue

Neurological--❒Neg

No Yes
- ❍ ❍ difficulty walking
- ❍ ❍ headache
- ❍ ❍ dizziness
- ❍ ❍ seizure disorder
- ❍ ❍ difficulty with coordination

Immunologic--❒Neg

No Yes
- ❍ ❍ food allergies

Musculoskeletal❒Neg

No Yes
- ❍ ❍ arthritis
- ❍ ❍ back pain
- ❍ ❍ joint pain
- ❍ ❍ neck pain
- ❍ ❍ decreased muscle tone
- ❍ ❍ special needs (brace, wheelchair, etc)

Hema/Lymphatic❒Neg

No Yes
- ❍ ❍ easy bleeding
- ❍ ❍ enlarged lymph nodes
- ❍ ❍ easy bruising

❒ **All Negative**