

PEDIATRIC AND YOUNG ADULT UROLOGY MEDICAL QUESTIONNAIRE

Today's Date: _____

Patient's Name: _____ Date of Birth: _____

Patient currently lives with: Name _____ Relationship to Patient _____

Patient brought to office by: Name _____ Relationship to Patient _____

Primary Care Physician and phone number: _____

1. Reason for this visit and date of onset: _____
2. Born Premature: Y ___ N ___ If yes, explain: _____
3. Up to date on immunizations? Y ___ N ___
4. Any birth defects: Y ___ N ___ If yes, explain: _____
5. Drug Allergies: _____
6. Current medications (list all): _____
7. Circumcision: Y ___ N ___ When: _____
8. Hospitalizations: _____
9. Surgeries: _____
10. Other doctors you see and why: _____

UROLOGIC PROBLEMS (Check if any apply)

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Hesitancy | <input type="checkbox"/> Bowel control | <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Kidney infection |
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Burning | <input type="checkbox"/> Sexually transmitted disease | <input type="checkbox"/> Uses catheter |
| <input type="checkbox"/> Nighttime wetting | <input type="checkbox"/> Poor stream | <input type="checkbox"/> Stones | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Daytime wetting | <input type="checkbox"/> Urgency | <input type="checkbox"/> Urinary tract infection | <input type="checkbox"/> Urinary Reflux |
| <input type="checkbox"/> Incomplete emptying | <input type="checkbox"/> Straining | <input type="checkbox"/> Bladder infection | |
| <input type="checkbox"/> Other _____ | | | |

MEDICAL HISTORY OF CHILD (Check if any apply)

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Asthma | <input type="checkbox"/> Cerebral Palsy |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Spinal bifida/MM |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Allergies | <input type="checkbox"/> GI Reflux | <input type="checkbox"/> Muscular dystrophy |
| <input type="checkbox"/> Abnormal menses | <input type="checkbox"/> Weight loss | <input type="checkbox"/> Mental retardation | <input type="checkbox"/> ADD/ADHD |
| <input type="checkbox"/> Bleeding problems | <input type="checkbox"/> Vision/hearing problems | <input type="checkbox"/> Developmental Delay | <input type="checkbox"/> HIV |
| <input type="checkbox"/> Other _____ | | | |

FAMILY HISTORY (Check if any apply to parents, siblings, and grandparents only)

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Kidney failure | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Kidney birth defects | <input type="checkbox"/> Bleeding problems | <input type="checkbox"/> Gastrointestinal Problems |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Urinary infections | <input type="checkbox"/> TB |
| <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Lung disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Vesicoureteral reflux |

To the best of my knowledge, this information is complete and accurate.

Signature

Date

Relationship to patient

Physician Use Only: (Comments/Notes)

Physician Signature: _____ Date Reviewed: _____