

# 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 (See Reverse Side)

## 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 \_\_\_\_\_

## Urologic Problems

Please take a moment to answer these questions with your child prior to your visit with University Pediatric Urology. This will help us better meet the needs of your child's urologic concerns. Also, if your child has had any lab work (urine tests, urine cultures) or any imaging (kidney/bladder ultrasounds, bladder x-rays, CT scans, etc) done, please be sure to have the records faxed to our office prior to your visit and have these studies put on a disc for our review.

How many times per day does your child typically urinate (pee)? \_\_\_\_\_

How often does your child have a bowel movement (poop)? \_\_\_\_\_

Does your child ever experience any straining or difficulty when having a bowel movement? Yes/No

Does your child have any bowel movement accidents? Yes/No

Have you ever noticed any blood in your child's urine that you can see with your own eyes? Yes/No

Does your child have any accidents during the daytime?

If so, how often? \_\_\_\_\_

Does your child have any accidents at nighttime (bedwetting)?

If so, how often? \_\_\_\_\_

Has your child ever had a urinary tract infection? Yes/No

If the answer is yes:

How many has your child had (approximately)? \_\_\_\_\_

Age of first infection \_\_\_\_\_

How many urinary tract infections has your child had in the past 6 months? \_\_\_\_\_

Have urine cultures ever been done (send urine to the lab for 48 hours)? Yes/No

Has your child ever had a fever with an infection? Yes/No If so, how high? \_\_\_\_\_

Has your child ever had any ultrasounds, x-rays, or additional tests done for this problem?

If so, what tests have been done? \_\_\_\_\_

Other Urologic Problems (Check if any apply)

- |  |                                      |   |
|--|--------------------------------------|---|
| <input type="checkbox"/> Hesitancy           | <input type="checkbox"/> Poor stream | <input type="checkbox"/> Sexually transmitted disease |
| <input type="checkbox"/> Incomplete emptying | <input type="checkbox"/> Urgency     | <input type="checkbox"/> Stones                       |
| <input type="checkbox"/> Burning             | <input type="checkbox"/> Straining   | <input type="checkbox"/> Urinary Reflux               |
| <input type="checkbox"/> Other _____         |                                      |   |