Pediatric Surgical Services, Inc.

Urology Focused

New Patient Medical History Questionnaire

To assist us in caring for your child, please complete the following questionnaire

Why are you here today?
What has been done thus far for this problem? (i.e. lab tests, X-rays, ultrasounds, MRT, CT, VCUG, medications)

UROLOGY HISTORY					
Has the patient experienced any of the following symptoms? Please circle the correct answer					
Infections Bladder/Kidney	No	Yes	When did they start?		Last infection?
With fever	No	Yes	How many?		Highest temp?
Hospitalization necessary?	No	Yes	When?		Where?
Blood in urine	No	Yes	How many times has this occurred?		
Seen in urine test	No	Yes			
See visibly	No	Yes			
Dribbles or leaks urine	No	Yes	Rarely	Occasionally	Frequently
Frequency urinates	No	Yes	Rarely	Occasionally	Frequently
Pain when urinating	No	Yes	Rarely	Occasionally	Frequently
Sudden urge(s) to urinate	No	Yes	Rarely	Occasionally	Frequently
Squats/grabs crotch to stop wetting	No	Yes	Rarely	Occasionally	Frequently
Constipation problems	No	Yes	Rarely	Occasionally	Frequently
Stool stains in pants	No	Yes	Rarely	Occasionally	Frequently
Potty training	No	Yes	What age?		
Problems with toilet training	No	Yes	Please explain:		
Gets up at night to urinate	No	Yes	Rarely	Occasionally	Frequently
Wets the bed	No	Yes	Rarely	Occasionally	Frequently
Wears Pull-ups at night	No	Yes			
Dry nights for a long period	No	Yes	How long did it last?		

HISTORY OF PATIENT'S BIRTH				
Mother's pregnancy with patient was:	Full Term		Ended early, @ _____ wks. Gestation	
Delivery was:	Vaginal		Scheduled C-section	Emergency C-Section
Complicated pregnancy or delivery?	No	Yes	Please explain:	
Medications taken while pregnant?	No	Yes	What?	

PAST MEDICAL HISTORY					
Hospitalizations	No	Yes	When?	Where?	Why?
Surgeries	No	Yes	When?	Where?	Why?
Blood Transfusions	No	Yes	When?	Where?	
Contagious Disease	No	Yes	What?	Where?	
Psychological Care	No	Yes	When?	Where?	Why?
Is child still receiving psychological care?	No	Yes	By whom?		

MENSTRATING TEENAGE GIRLS ONLY

Age when got first period?				
How often does pt. get her period?				
How long do periods usually last?				
What is her flow like?	Light	Average	Heavy	Irregular

CHILDS FAMILY HISTORY

Have any blood-related patient, sibling, grandparent, aunt, uncle or cousin of the patient had problems concerning:

Anesthetic	No	Yes	Who?	Deceased?	No	Yes	Age:
Asthma	No	Yes	Who?	Deceased?	No	Yes	Age:
Bleeding	No	Yes	Who?	Deceased?	No	Yes	Age:
Cancer	No	Yes	Who?	Deceased?	No	Yes	Age:
Developmental delays	No	Yes	Who?	Deceased?	No	Yes	Age:
Diabetes	No	Yes	Who?	Deceased?	No	Yes	Age:
Heart Disease	No	Yes	Who?	Deceased?	No	Yes	Age:
Liver or kidney disease	No	Yes	Who?	Deceased?	No	Yes	Age:
Seizures	No	Yes	Who?	Deceased?	No	Yes	Age:
Tuberculosis	No	Yes	Who?	Deceased?	No	Yes	Age:
Bedwetting	No	Yes	Who?	Deceased?	No	Yes	Age:
Other							

SIGNIFICANT FAMILY MEDICAL HISTORY (especially urology issues)

_____

_____

SOCIAL HISTORY

Patient's parents are:	Married	Unmarried	Divorced	Separated	Widowed (one parent is deceased)
Who does patient live with?					
If not blood-related, please specify. (For example; a step or adopted brother or sister.)	Brother(s) Age			Sister(s) Age	

Attends school	No	Yes	Grade
School performance	Good	Poor	
Learning disabilities	No	Yes	What type?
Attends after-school program	No	Yes	
Extracurricular changes	No	Yes	What type?
Experiencing new changes or stresses	No	Yes	Explain:

CURRENT MEDICATIONS

Medication and dose	Homeopathic or Natural Remedies/vits
1. _____	1. _____
2. _____	2. _____
3. _____	3. _____
4. _____	4. _____

REVIEW OF SYSTEMS

Has the patient had any problems with:

HEENT (head/eyes/ears/throat)			**Musculoskeletal (muscle and bone)**		
Headaches	No	Yes	Muscles	No	Yes
Eyes	No	Yes	Bones	No	Yes
Ears	No	Yes	Arms	No	Yes
Nose	No	Yes	Legs	No	Yes
Swollen glands	No	Yes	Hips	No	Yes
Sinus problems	No	Yes	Back	No	Yes
Pulmonary (lungs)			Feet	No	Yes
Asthma/Wheezing	No	Yes	**Hematologic/Lymph (blood)**		
Persistent Cough	No	Yes	Clotting problems	No	Yes
Shortness of Breath	No	Yes	Bleeding problems	No	Yes
Cardiac (heart)	No	Yes	Bruising easily	No	Yes
Heart defect(s)	No	Yes	**Neurologic (nervous system)**		
Skin turning blue	No	Yes	Head Injury	No	Yes
Heart murmur(s)	No	Yes	Seizures	No	Yes
Palpitations	No	Yes	**Psychological**	No	Yes
GI (digestive system)			Depression	No	Yes
Stomach	No	Yes	Anxiety/nervousness	No	Yes
Constipation	No	Yes	Sleep disorder	No	Yes
Diarrhea	No	Yes	**Integumentary**	No	Yes
Nausea/Vomiting	No	Yes	Poor wound healing	No	Yes
			Rashes		
Allergies	No	Yes	To what?		
Endocrine (hormonal system)					
Excessive appetite	No	Yes	Weight problem	No	Yes
Excessive thirst	No	Yes	Cold/heat intolerance	No	Yes

_____ _____

Provider Signature Date

Date Reviewed	Prov. Initials		Date Reviewed	Prov. Initials		Date Reviewed	Prov. Initials		Date Reviewed	Prov. Initials

Note: Changes to ROS, medical, family and social history is documented in progress note.