



Name: _____
MR#: _____ Finance: _____
DOB: _____
MD: _____

New Patient Medical History

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

Patient Name: _____ Date of Birth: _____

Why are you here today?

<i>What has been done thus far for this problem?</i>				
Lab Tests	No	Yes	Which ones?	When?
X-Rays	No	Yes	Which ones?	When?
Ultrasound	No	Yes	Which ones?	When?
MRI, CT	No	Yes	Which ones?	When?
VCUG	No	Yes		When?
Medicine for urine/kidney infection or wetting?	No	Yes	What?	When?
Any remedies tried for infection or wetting?	No	Yes	What?	When?

UROLOGY HISTORY

<i>Has the patient experienced any of the following symptoms? Please circle the correct answer.</i>					
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			
Seen visibly	No	Yes			
Dribbles or leaks urine	No	Yes	Rarely	Occasionally	Frequently
Frequently 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 trained	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 HISTORY

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	Why?	When?
Surgeries	No	Yes	Why?	When?
Blood Transfusions	No	Yes	When?	
Contagious Diseases	No	Yes	What?	
Psychological Care	No	Yes	Why?	When?
Is child still receiving psychological care	No	Yes	By whom?	

New Patient Medical History (continued)

Patient Name: _____ **Date of Birth:** _____

MENSTRUATING 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

<i>Has any blood-related parent, sibling, grandparent, aunt, uncle or cousin of the patient had problems concerning:</i>							
Anesthesia	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?	Until what age?			

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 <i>not</i> blood-related, please specify. (For example; a step, or adopted brother or sister.)	Brother(s) / Age _____ _____ _____	Sister(s) / Age _____ _____ _____	Condition of Health _____ _____ _____		
Attends school	No	Yes	Grade:		
School performance	Good	Poor			
Learning disabilities	No	Yes	What type?		
Attends after-school program	No	Yes			
Extracurricular activities	No	Yes	What type?		
Experiencing new changes or stresses	No	Yes	Explain:		

IMMUNIZATIONS

Diphtheria, Tetanus and Pertusis	No	Yes	Date
Polio	No	Yes	Date
Hepatitis B1	No	Yes	Date
Hepatitis B2	No	Yes	Date
Hepatitis B3	No	Yes	Date
Hib	No	Yes	Date
Measles, Mumps, Rubella	No	Yes	Date
Varicella (Chicken Pox)	No	Yes	Date

New Patient Medical History (continued)

Patient Name: _____ Date of Birth: _____

ALLERGIES

Latex	No	Yes	
Food(s)	No	Yes	
Other Substances	No	Yes	
Medications	No	Yes	Which Medications?

CURRENT MEDICATIONS

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

REVIEW OF SYSTEMS

<i>Has the patient had any problems with:</i>					
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)			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		
GI (digestive system)			Depression	No	Yes
Stomach	No	Yes	Anxiety/nervousness	No	Yes
Constipation	No	Yes	Sleep disorder	No	Yes
Diarrhea	No	Yes	Integument (skin)		
Nausea / Vomiting	No	Yes	Poor wound healing	No	Yes
			Rashes	No	Yes
Endocrine (hormonal system)					
Excessive appetite	No	Yes	Weight problem	No	Yes
Excessive thirst	No	Yes	Cold / heat intolerance	No	Yes

CONTACT INFORMATION	Father	Mother
Place of Employment		
Occupation		
Phone Number(s)	Work:	Work:
	Home:	Home:
	Other:	Other:

Name of Person Filling out Form: _____ Date: _____

Relationship to Patient: _____

Physician Signature: _____ Date: _____