



Last Name _____ First Name _____
 Date of Birth: ____/____/____ Social Security Number: _____
 Referring Physician: _____ Phone #: _____
 Physician Address: _____
 Pharmacy: _____ Phone #: _____
 Pharmacy Address: _____

History of Present Illness

Please answer the following questions

Chief Complaint

What is the main reason for your child’s visit today?

- Urinary Tract Infections
- Hydronephrosis
- Urinary Frequency
- Bedwetting
- Penile Adhesions
- Undescended Testis
- Other: _____
- Proteinuria (Protein in Urine)
- Kidney Stones
- Urinary Incontinence
- Hydrocele
- Circumcision

Which best describes your child’s symptoms? Check all that apply.

- Frequent Urination—day, night, or both
- Sudden or strong urge to urinate
- Leakage with little or no warning----sometimes unable to make it to the bathroom in time
- Unable to completely empty the bladder----feels like there is more even after going to the bathroom
- Accidental leakage with physical activity---exercising, sneezing, or coughing
- Bladder or pelvic pain
- Problems with bowel function (if checked, please select symptom below)
 - Accidental loss or leakage of stool
 - Constipation
 - Other
- No Bladder or bowel problems (if checked, please skip and continue to Past Medical History form)
- How long has your child had these symptoms? _____
- Has your child tried medications to help his/her bladder symptoms? Yes No
- If yes, how many different medications has he/she tried? _____



Past Medical & Social History

Please answer the following questions

Medical History

Please check if **your child** has ever had any of the following:

- High Blood Pressure
- Lung (COPD, Asthma)
- Diabetes
- Thyroid
- GERD
- Seizures/Epilepsy
- High Cholesterol/triglyceride
- Sexually transmitted disease
- Cancer:
Type _____
- Kidney/Bladder (Renal Cyst, Renal Mass, Stones)
- Anxiety, depression or mental illness
- Blood disorders (abnormal bleeding anemia, high or low white count)
- Other _____

Surgical History

1. Has your child ever had surgery? Yes No
2. Please list approximate dates and reasons for any surgery:

Date	Surgeries
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Allergies

Does your child have any allergies? Yes No
If yes please specify below:

_____	_____
_____	_____
_____	_____

Medications

1. Please list any prescription medications your child is currently taking and their dosage

Medication Name	Dosage	Reason for taking

2. Please indicate if your child is taking any of the following over the counter medications:

- Aspirin Tylenol Advil/Motrin/Ibuprofen
- Antacid Laxatives Decongestants
- Antihistamines Vitamins/Mineral Supplements
- Other: _____

Family History

Please list all serious illnesses in your immediate family; (Example: Diabetes, Cancer, Tuberculosis, Heart disease)

Mother: Age _____ Living: _____
 Deceased-Cause: _____
 Father: Age _____ Living: _____
 Deceased-Cause: _____
 Sister: _____
 Brother: _____



Review of symptoms

Is your child currently having problems with the following? Circle yes (y) or no (N)

Constitutional Symptoms

Fever	Y N
Chills	Y N
Sweats	Y N
Weakness	Y N
Fatigue	Y N

Eyes

Blurred Vision	Y N
Double Vision	Y N
Pain	Y N

Immunologic

Recurrent Fevers	Y N
Recurrent Infections	Y N
Malaise	Y N

Neurological

Confusion	Y N
Numbness/Tingling	Y N
Dizzy Spells	Y N
Headache	Y N

Endocrine

Excessive Thirst	Y N
Too hot/Cold	Y N
Excessive Hunger	Y N

Gastrointestinal

Abdominal Pain	Y N
Nausea/Vomiting	Y N
Indigestion/heartburn	Y N
Diarrhea	Y N

Cardiovascular

Chest Pain	Y N
Palpitations	Y N
Ankle Swelling	Y N

Integumentary

Skin Rash	Y N
Boils	Y N
Persistent itch	Y N
Burns	Y N
Skin Lesion	Y N

Musculoskeletal

Joint pain	Y N
Neck Pain	Y N
Back Pain	Y N

Ears/Nose/Throat/Mouth

Ear Infection	Y N
Sore Throat	Y N
Sinus Problems	Y N

Genitourinary

Urine Retention	Y N
Painful Urination	Y N
Urinary Frequency	Y N
Blood in Urine	Y N

Respiratory

Wheezing	Y N
Frequent Cough	Y N
Shortness of breath	Y N

Hematologic/Lymphatic

Swollen glands	Y N
Blood clotting problems	Y N
Bruising tendency	Y N

Psychologic

Depression	Y N
Anxiety	Y N

Physician Signature: _____

Date: _____



**Ambulatory Care
Authorization to Discuss PHI with a Designee**

Patient's Name: _____ Date of Birth: _____
(Please Print Clearly) (Please Print Clearly)

By signing below I hereby give permission to _____
(Name of Physician, Physician Practice or Service Practice)

to discuss with the following individuals information related the health care services I receive at the above-named physician's office/physician practice. I agree that this information will be limited to appointment scheduling (date and time), procedure scheduling (date, time and preparation information) prescription re-fill(s), laboratory test results, radiology examination results and billing inquiries. I agree that this does not include the ability for the individuals noted below to authorize the disclosure of my protected health information to a third party or to request on my behalf a copy of my health information. I agree that this authorization will remain active until I revoke it by submitting an updated authorization to the physician practice noted above.

- Name of Individual _____ Relationship to patient _____
- Name of Individual _____ Relationship to patient _____
- Name of Individual _____ Relationship to patient _____
- Name of Individual _____ Relationship to patient _____
- Name of Individual _____ Relationship to patient _____
- Name of Individual _____ Relationship to patient _____

Signature of Patient _____

Date _____ Time _____

For Office Use Only

Patient's MRN _____

Date received: _____