CHOC CHILDREN'S UROLOGY CENTER

Patient's Name_____ Age_____ Gender_____

Has your child ever had:

___Urinary Tract Infection w/ Fever
___Pyelonephritis
___Hydronephrosis
___Vesicoureteral Reflux
___Multi Cystic Dysplastic Kidney
___Hernia
___Hydrocele
___Undescended Testicle
___Balanitis
___Kidney Stone
___Urinary Retention
___Incontinence (Day)
___Incontinence (Night)
___Frequency Urination
___Urgency Urination
___Constipation
___Spina Bifida
___Neurogenic Bladder
___Posterior Urethral Valves
___ MRSA
___Other _____
___Other _____

Has your child ever had a serious illness, and if so what _____
Has your child ever had to stay overnight in the hospital, and if so why _____

Has your child ever had any surgeries? Please check all that apply

___Circumcision
___Hypospadias Repair; How many?
___Pyeloplasty
___Nephrectomy
___Ureteral Reimplant
___Deflux
___Hernia Repair
___Hydrocelectomy
___Orchidopexy
___Cystoscopy
___Bladder Augment
___Mitrofanoff
___ACE
___Other _____
___Other _____

ALLERGIES: _____

Medicine that your child takes everyday: _____

FAMILY HISTORY	AGE	OVERALL HEALTH (Good, Fair, Poor)	OCCUPATION	SPECIFIC HEALTH CONDITIONS	IF DECEASED, AGE AT TIME OF DEATH	CAUSE OF DEATH
Parent						
Parent						
Sibling						
Sibling						
Sibling						
Other						
Other						

Has any biological family member ever had any of the following:

___Polycystic Kidney Disease
___Renal (Kidney) Cancer
___Testicular Cancer
___Bed Wetting
___Bladder Cancer
___Kidney Cysts
___Vesicoureteral Reflux
___Dialysis
___Hydronephrosis
___Bleeding Problems
___Diabetes

Has your child been in good health most of their life? yes no

In the past had your child eve had any of the following:

Skin disease	yes	no	Vomiting blood	yes	no
Jaundice	yes	no	Gallbladder disease	yes	no
Hives, eczema, rash	yes	no	Change in appetite	yes	no
Dry eyes or mouth	yes	no	Hepatitis	yes	no
Bleeding gums	yes	no	Painful bowel movements	yes	no
Blurred vision	yes	no	Bleeding with bowel movements	yes	no
Frequent nose bleeds	yes	no	Black stools	yes	no
Chronic sinus trouble	yes	no	Hemorrhoids	yes	no
Ear disease	yes	no	Recent change in bowel movements	yes	no
Impaired hearing	yes	no	Frequent diarrhea	yes	no
Dizziness	yes	no	Heartburn or indigestion	yes	no
Frequent or severe headaches	yes	no	Cramping or pain in the abdomen	yes	no
Asthma or wheezing	yes	no	Hormone therapy	yes	no
Difficulty breathing	yes	no	Neck stiffness	yes	no
Lung trouble	yes	no	Enlarged glands	yes	no
Pneumonia	yes	no	Loss of urine	yes	no
Chest pain, pressure or tightness	yes	no	Blood in urine	yes	no
Difficulty walking two blocks	yes	no	Frequent urination	yes	no
Palpitations	yes	no	Burning or painful urination	yes	no
Swelling of hands, feet or ankles	yes	no	Night time urination	yes	no
Heart murmur	yes	no	Kidney trouble	yes	no
Abnormal vaginal discharge	yes	no	Problem stopping/starting flow urine	yes	no
Urine coming from vagina	yes	no	Testicular mass	yes	no
Pregnancy	yes	no	Testicular pain	yes	no
Anemia	yes	no	STD or AIDS	yes	no
Abnormal bruising	yes	no	Walking with toe(s) turned in	yes	no
Abnormal bleeding	yes	no	Had a consult for mental health	yes	no
Weakness in muscles or joints	yes	no	Domestic violence	yes	no
Tingling sensation down either leg	yes	no	Physical/verbal abuse	yes	no
Walking on toes	yes	no	Sexual abuse	yes	no
Fainting spells	yes	no	Autism spectrum disorder, ADD, ADHD	yes	no
Convulsions/seizures	yes	no	Depression symptoms (difficulty sleeping,		
Paralysis	yes	no	loss of appetite, loss of interest in activities,		
			feeling of hopelessness)	yes	no

Signature of parent of guardian: Date:

Relationship to patient: Health Provider Signature: