If new patient or have not been seen in the past year, please complete this form.

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: _____
11. Other medical problems: _____

_____

MEDICAL HISTORY OF CHILD (Check if any apply)

❑ Cancer	❑ Heart Problems	❑ Asthma	❑ Cerebral Palsy	❑ Bleeding problems
❑ Seizures	❑ Heart murmur	❑ Diabetes	❑ Spinal bifida/MM	❑ Vision/hearing problems
❑ Hepatitis	❑ Allergies	❑ GI Reflux	❑ Muscular dystrophy	❑ Developmental Delay
❑ Abnormal menses	❑ Weight loss	❑ Intellectual disability	❑ ADD/ADHD	❑ HIV
❑ Other_____				

FAMILY HISTORY (Check if any apply to parents, siblings, and grandparents only)

❑ Cancer	❑ Kidney failure	❑ Hepatitis	❑ Stroke	❑ Kidney Stones
❑ Seizures	❑ Kidney birth defects	❑ Bleeding problems	❑ Gastrointestinal problems	
❑ Arthritis	❑ Heart problems	❑ Urinary infections	❑ TB	
❑ Thyroid problems	❑ Lung disease	❑ Diabetes	❑ Vesicoureteral reflux	

To the best of my knowledge, this information is complete and accurate.

_____

Signature Date Relationship to patient