



CHOC CHILDREN'S UROLOGY CENTER

Patient's Name _____ Age _____ Gender _____

Has your child ever had:

- | | | |
|---|---|--|
| <input type="checkbox"/> Urinary Tract Infection w/ Fever | <input type="checkbox"/> Balanitis | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Pyelonephritis | <input type="checkbox"/> Kidney Stone | <input type="checkbox"/> Neurogenic Bladder |
| <input type="checkbox"/> Hydronephrosis | <input type="checkbox"/> Urinary Retention | <input type="checkbox"/> Posterior Urethral Valves |
| <input type="checkbox"/> Vesicoureteral Reflux | <input type="checkbox"/> Incontinence (Day) | <input type="checkbox"/> MRSA |
| <input type="checkbox"/> Multi Cystic Dysplastic Kidney | <input type="checkbox"/> Incontinence (Night) | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Hernia | <input type="checkbox"/> Frequency Urination | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Hydrocele | <input type="checkbox"/> Urgency Urination | |
| <input type="checkbox"/> Undescended Testicle | <input type="checkbox"/> Constipation | |

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

- | | | |
|--|---|--|
| <input type="checkbox"/> Circumcision | <input type="checkbox"/> Deflux | <input type="checkbox"/> Bladder Augment |
| <input type="checkbox"/> Hypospadias Repair; How many? | <input type="checkbox"/> Hernia Repair | <input type="checkbox"/> Mitrofanoff |
| <input type="checkbox"/> Pyeloplasty | <input type="checkbox"/> Hydrocelectomy | <input type="checkbox"/> ACE |
| <input type="checkbox"/> Nephrectomy | <input type="checkbox"/> Orchidopexy | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Ureteral Reimplant | <input type="checkbox"/> Cystoscopy | <input type="checkbox"/> 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:

- | | | |
|--|--|--|
| <input type="checkbox"/> Polycystic Kidney Disease | <input type="checkbox"/> Bladder Cancer | <input type="checkbox"/> Hydronephrosis |
| <input type="checkbox"/> Renal (Kidney) Cancer | <input type="checkbox"/> Kidney Cysts | <input type="checkbox"/> Bleeding Problems |
| <input type="checkbox"/> Testicular Cancer | <input type="checkbox"/> Vesicoureteral Reflux | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Dialysis | |

Has your child been in good health most of their life? yes no
In the past had your child ever 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, loss of appetite, loss of interest in activities, feeling of hopelessness)	yes	no
Paralysis	yes	no			

Signature of parent of guardian:

Date:

Relationship to patient:

Health Provider

Signature:

