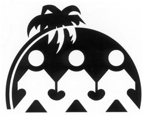

Children's Urology Group

New Patient Questionnaire

MED REC NO: ________________ ACCT NO: __________________

PATIENT: ____

DATE: ________________________ LOCATION: ________________

DOB: _________________________ AGE: ______________________

SOURCE OF INFORMATION

Primary Care Physician: ______________________________________
Referring Physician: ______________________________________
Person Providing Information: ______________________________________
Relationship to Patient: ______________________________________
Language Spoken: ______________________________________
Chief Complaint: ______________________________________
Reason for Referral: ______________________________________

HISTORY – PRESENT ILLNESS

Question		
Has the patient had Bladder/Kidney/Urinary Tract Infections?	No	Yes
Has the patient had fever with these infections?	No	Yes
Does the patient have pain when urinating?	No	Yes
Have you seen blood in the urine?	No	Yes
Has a test shown blood in the urine?	No	Yes
Has the patient had problems with constipation?	No	Yes
Is the patient toilet trained?	No	Yes
Does the patient leak urine during the day?	No	Yes
Does the patient get up to urinate at night?	No	Yes
Does the patient wet the bed?	No	Yes
Does the patient get much warning about needing to urinate?	No	Yes
How often does the patient urinate during the day?	__________	
Does the patient urinate upon arising each morning?	No	Yes
Does the patient squat or cross legs to hold urine?	No	Yes
Does the patient have urine accidents in daytime?	No	Yes

PAST HISTORY

Question		
Was birth normal full term?	No	Yes
If not, how early?	__________	
Are immunizations up to date?	No	Yes
Is patient allergic to anything?	No	Yes

If yes, please list: ______________________________________
Please list reactions: ______________________________________

Is the patient taking medications: prescribed or over the counter (Tylenol/Vitamins)? No Yes

Please List:

Medications	Dose	Times Per Day
__________________________	____________	_________
__________________________	____________	_________
__________________________	____________	_________
__________________________	____________	_________

Has the patient had any x-rays, ultrasounds or scans on kidneys or bladder; any blood in urine tests?

What	When	Where
__________________________	____________	_________
__________________________	____________	_________
__________________________	____________	_________
__________________________	____________	_________

If the patient is female, is she menstruating yet? No Yes

Has the patient ever been hospitalized? No Yes
If yes, please list reason/when: ______________________________________
____

Has the patient had any operations? No Yes
If yes, please list what/when: ______________________________________
____
____
____

FAMILY HISTORY

Do any family members have kidney/urologic problems/diagnosis of bedwetting? No Yes
If yes, please list family member and problem: ________________________
____
____

SOCIAL HISTORY

Patient lives with: Mom Dad Grandparents Guardian Foster Aunt Uncle Brother Sister Other
Please list other: ______________________________________

Question		
Are the parents separated?	No	Yes
Are the parents divorced?	No	Yes
Are you a single parent family?	No	Yes
Is the patient in day care?	No	Yes

Patient's Grade Level: ______________________________________

School Performance: A B C D E F Pass Fail

Is the patient missing school frequently? No Yes

REVIEW OF SYSTEMS

Has the patient had any of the following problems?
If yes, describe.

Problem		
Brain problems/seizures	No	Yes ________________________
Heart problems	No	Yes ________________________
Breathing problems	No	Yes ________________________
Sleeping problems/Snoring	No	Yes ________________________
Stomach problems	No	Yes ________________________
Bladder/Kidney problems	No	Yes ________________________
Thyroid problems	No	Yes ________________________
Bone/Muscle Problems	No	Yes ________________________
Diabetes	No	Yes ________________________
Cancer	No	Yes ________________________
Frequent Infections	No	Yes ________________________
Bleeding problems:	No	Yes ________________________
Development/Learning problems	No	Yes ________________________

SIGNATURES

Family Comments:

Parent/Legal Guardian Signature: ______________________________
Date: ____________________ Time: ____________________________
Translator Name: ______________________________________
Translator Signature: ______________________________________
Date: ____________________ Time: ____________________________

Staff Notes:

I have reviewed the above information.
Staff Signature/Title: ______________________________________
Date: ____________________ Time: ____________________________
Attending Signature/Title: ______________________________________
Date: ____________________ Time: ____________________________