Children's Urology Questionnaire

Name: _____ **DOB**: _____ **Date**: _____

Reason for appointment: _____

_____

_____

****For the next four fields, you may WRITE YOUR RESPONSES or CHECK THE BOXES on pages 2-4****

Today's Symptoms- Please list/describe your symptoms. See page 3 for a list of common problems.

_____

_____

Past Medical History- Please list all known conditions, past and present. See page 3 if you need assistance.

- _____
- _____
- _____
- _____
- _____
- _____

Past Surgical History- Please list all surgeries. See page 4 for a list of common procedures.

- _____Month/Year:_____
- _____Month/Year:_____
- _____Month/Year:_____
- _____Month/Year:_____

Medications- Please list all current medications. See page 2 for a list of common drugs.

- _____Dose/Strength:_____
- _____Dose/Strength:_____
- _____Dose/Strength:_____

- Please list any medication allergies: _____

Social History

Lives with: MOM DAD RELATIVE OTHER: ____ (Please circle all that apply)

Siblings? Yes / No If yes, list # of brothers:_____ sisters:_____

School Performance: Very Good Good Fair Poor Very Poor (Please circle one)

Name:_____**DOB:**_____**Date**_____

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Common Medications (Please check all that apply)

- ☐ Advair Diskus
- ☐ Albuterol
- ☐ Allergy Medication:_____
- ☐ Ambien
- ☐ Antibiotics:_____
- ☐ Antidepressant:_____
- ☐ Ativan (Lorazapam)
- ☐ Celebrex
- ☐ Coumadin (Warfarin Sodium)
- ☐ Effexor
- ☐ Furosemide
- ☐ Gabapentin (Neurontin)
- ☐ Hydrochlorothiazide
- ☐ Ibuprofen
- ☐ Klonopin (Clonazepam)
- ☐ Levothyroxine
- ☐ Lipitor
- ☐ Lisinopril
- ☐ Metformin (Glucophage)
- ☐ Metoprolol
- ☐ Naproxen
- ☐ Nexium (Esomeprazole)
- ☐ Norvasc

- ☐ Pantoprazole
- ☐ Plavix
- ☐ Potassium Chloride
- ☐ Prednisone
- ☐ Premarin
- ☐ Prevacid
- ☐ Prilosec (Omeprazole)
- ☐ Prozac
- ☐ Simvastatin (Zocor)
- ☐ Singulair
- ☐ Synthroid (Levothyroxine)
- ☐ Tylenol
- ☐ Xanax
- ☐ Other:_____
- ☐ Other:_____
- ☐ Other:_____
- ☐ Other:_____

Name:_____**DOB:**_____**Date**_____

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Today's Symptoms (check boxes for any that apply)

Genitourinary/Urologic

- ☐ Blood in Urine
- ☐ Dribbling or Weak Stream (Circle One)
- ☐ Burning with Urination
- ☐ Erection/Ejaculation Problem (Circle One)
- ☐ Kidney/Bladder Stone(s) (Circle One)
- ☐ Bladder/Kidney Infection (Circle One)
- ☐ Sensation of Not Emptying
- ☐ Bladder Pain
- ☐ Testicular/Scrotal Swelling
- ☐ Urinary Urgency/Frequency/Hesitancy (Circle One)
- ☐ Urinary Incontinence
- ☐ Urinary Tract Infection
- ☐ Inability to Urinate
- ☐ Prostatitis
- ☐ Bedwetting
- ☐ Vaginal Bleeding/Discharge (Circle One)
- ☐ Flank/Kidney Pain
- ☐ Other_____

Constitutional

- ☐ Appetite Change
- ☐ Chills
- ☐ Fever
- ☐ Fatigue
- ☐ Night Sweats
- ☐ Weight Loss
- ☐ Other_____

Eyes

- ☐ Blindness
- ☐ Blurred Vision
- ☐ Other_____

Neurological

- ☐ Dizzy Spells
- ☐ Headache

☐ Leg or Arm Weakness (Circle One)

☐ Memory Loss

☐ Numbness/Tingling

☐ Other_____

Gastrointestinal

☐ Abdominal Pain

☐ Acid Reflux

☐ Constipation

☐ Diarrhea

☐ Hemorrhoids

☐ Indigestion/Heartburn

☐ Nausea/Vomiting

☐ Rectal Bleeding/Bloody Stools

☐ Tarry Stool

☐ Other_____

Cardiovascular

☐ Chest Pain/Angina

☐ Irregular Heartbeat/Palpitations (Circle One)

Skin

☐ Rash

☐ Other_____

Musculoskeletal

☐ Back Pain

☐ Joint Pain

☐ Muscle Cramps/Spasms

☐ Other_____

Ears/Nose/Throat

☐ Ear Infection

☐ Sinus Congestion

☐ Other_____

Respiratory

☐ Asthma

☐ Emphysema/Bronchitis (Circle One)

☐ Cough

☐ Shortness of Breath

☐ Other_____

Psychological

☐ Anxious/Depressed (Circle One)

☐ Other_____

Name:_____**DOB:**_____**Date**_____

Health History (Check boxes for any conditions that apply, past or present)

☐ Anemia
☐ Angina
☐ Anxiety
☐ Arrhythmia
☐ Aortic Aneurysm
☐ Asthma
☐ Atrial Fibrillation
☐ Bleeding Disorder
☐ Bronchitis
☐ Chronic Fatigue
☐ Colitis
☐ Constipation
☐ Crohn's Disease
☐ Depression
☐ Diabetes
  ☐ Type 1
  ☐ Type 2
☐ Emphysema
☐ Epilepsy
☐ Fibromyalgia
☐ GERD
☐ Glaucoma
☐ Heart Disease
☐ Heart Murmur
☐ Hemorrhoids
☐ Hepatitis
☐ Herniated Disc
☐ Hiatal Hernia
☐ Hypertension
☐ Irritable Bowel Disease
☐ Kidney Disease
☐ Kidney Infection
☐ Migraine
☐ Mitral Stenosis
☐ Mitral Insufficiency
☐ Mitral Valve Prolapse
☐ Peptic Ulcer
☐ Phlebitis
☐ Prostatitis
☐ Rheumatic Fever

☐ Tuberculosis **Site:**_____ **Type:**_____ ☐ Other:_____

☐ Transplant Recipient ☐ Cancer ☐ Other:_____

Surgical History (Please check all that apply, and provide Month/Year)

☐	Appendectomy	☐	Oral Surgery Type:
	Date:		Date:
☐	Cataract Surgery:	☐	Cardiovascular Surgery: Type
	Date:		Date:
☐	Gallbladder Removal:	☐	Urologic Surgery, Type
	Date:		Date:
☐	Tosillectomy	☐	Other
	Date:		Date:
☐	Hernia Repair: Type:	☐	Other
	Date:		Date: