

Pediatric Urology – Loyola University Medical Center

PATIENT HISTORY FORM

Name
MR#

Note: This is a confidential record and will be kept in your doctor's office.
Information contained here will not be released to anyone without your authorization to do so.

Today's Date: _____	MR# _____
Patient's Name: _____	Date of Birth: _____
Parent's Name: _____	Home Phone #: _____
Address: _____	Work #: _____ (mom/dad)
	Email address: _____

Patient's Pediatrician: _____

Address: _____

Phone: _____

Chief Complaint:
What is the main reason for your child's visit today?
(Describe the problem in detail)

Who referred you today?

Pediatric/Primary MD: _____

Other MD name: _____

Self Website Other: _____

Friend name: _____

History of Present Illness

Please answer the following questions

Location of the problem

Abdomen Back Kidney Bladder

Other: _____

Describe the problem: _____

On a Scale of 1 – 10, with 10 being the most severe, circle the number that best describes the problem?

1 2 3 4 5 6 7 8 9 10

When did you first notice the problem?

Since Birth Days ago Weeks ago Months ago

Other: _____

Does anything make the problem better? Yes No

Explain: _____

Does anything make the problem worse? Yes No

Explain: _____

How long does the problem last?

30 min ___ Hours ___ Days ___ It is always there

Other: _____

Does anything else occur at the same time? Yes No

Explain: _____

Does the problem interfere with normal functions? Yes / No

Explain: _____

Physician use only: (Comments/Notes)	Dx.					
	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; text-align: center; font-size: small;"># Answer</td> <td style="width: 50%; text-align: center; font-size: small;">Level of Service</td> </tr> <tr> <td style="text-align: center; font-size: small;">1 - 3</td> <td style="text-align: center; font-size: small;">1 or 2</td> </tr> <tr> <td style="text-align: center; font-size: small;">4+</td> <td style="text-align: center; font-size: small;">3 - 5</td> </tr> </table>	# Answer	Level of Service	1 - 3	1 or 2	4+
# Answer	Level of Service					
1 - 3	1 or 2					
4+	3 - 5					

(over)

Past Medical & Social History

Was the patient born prematurely? No Yes How early? _____

Family History. Has any blood relative had:

<input type="checkbox"/> Urine infection	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sibling	<input type="checkbox"/> Aunt	<input type="checkbox"/> Uncle	<input type="checkbox"/> Cousin	<input type="checkbox"/> Grandfather	<input type="checkbox"/> Grandmother	Other _____
<input type="checkbox"/> Reflux	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sibling	<input type="checkbox"/> Aunt	<input type="checkbox"/> Uncle	<input type="checkbox"/> Cousin	<input type="checkbox"/> Grandfather	<input type="checkbox"/> Grandmother	Other _____
<input type="checkbox"/> Bed wetting	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sibling	<input type="checkbox"/> Aunt	<input type="checkbox"/> Uncle	<input type="checkbox"/> Cousin	<input type="checkbox"/> Grandfather	<input type="checkbox"/> Grandmother	Other _____
<input type="checkbox"/> Genital birth defects	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sibling	<input type="checkbox"/> Aunt	<input type="checkbox"/> Uncle	<input type="checkbox"/> Cousin	<input type="checkbox"/> Grandfather	<input type="checkbox"/> Grandmother	Other _____

Type: _____

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sibling	<input type="checkbox"/> Aunt	<input type="checkbox"/> Uncle	<input type="checkbox"/> Cousin	<input type="checkbox"/> Grandfather	<input type="checkbox"/> Grandmother	Other _____
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sibling	<input type="checkbox"/> Aunt	<input type="checkbox"/> Uncle	<input type="checkbox"/> Cousin	<input type="checkbox"/> Grandfather	<input type="checkbox"/> Grandmother	Other _____
<input type="checkbox"/> Kidney failure/transplant	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sibling	<input type="checkbox"/> Aunt	<input type="checkbox"/> Uncle	<input type="checkbox"/> Cousin	<input type="checkbox"/> Grandfather	<input type="checkbox"/> Grandmother	Other _____
<input type="checkbox"/> Heart disease	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sibling	<input type="checkbox"/> Aunt	<input type="checkbox"/> Uncle	<input type="checkbox"/> Cousin	<input type="checkbox"/> Grandfather	<input type="checkbox"/> Grandmother	Other _____
<input type="checkbox"/> Cancer	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sibling	<input type="checkbox"/> Aunt	<input type="checkbox"/> Uncle	<input type="checkbox"/> Cousin	<input type="checkbox"/> Grandfather	<input type="checkbox"/> Grandmother	Other _____

Other _____ Who? _____

List patient's past surgeries.

Surgery	Date
_____	_____
_____	_____
_____	_____
_____	_____

List all of patient's medications. None

Medication	Dose
_____	_____
_____	_____
_____	_____
_____	_____

Who Lives at home? _____

Is the patient on a special diet? Yes No (if yes, explain)

Is the patient in school? Yes No

What grade? _____

Up to date on immunizations? Yes No

Physician use only.

Dry day
 Dry night
 Large volume
 Small volume
 Frequency
 Urgency
 Constipation

#	Level
0	1 or 2
1-2	3
3	4 or 5

Physician: _____

Date: _____