

# 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.

Today's Date: _____	MR# _____
Patient's Name: _____	Date of Birth: _____
Parent's Name: _____	Home Phone #: _____
Address: _____	Work/Cell Phone #: _____
_____	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?**

\_\_\_\_\_

Pediatrician  Friend  Relative  Other \_\_\_\_\_

### History of Present Illness

Please answer the following questions

**Location of the problem**

Abdomen  Back  Kidney  Bladder  Genitals

Other: \_\_\_\_\_

Describe the problem: \_\_\_\_\_

\_\_\_\_\_

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: \_\_\_\_\_

\_\_\_\_\_

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

Low/least 1 2 3 4 5 6 7 8 9 10 Worst

When did you first notice the problem?

Since Birth  Days ago  Weeks ago  Months ago

Other: \_\_\_\_\_

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

**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"/> Urine 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? \_\_\_\_\_

Was the patient born prematurely?  No  Yes How many weeks early? \_\_\_\_\_

List patient's past surgeries.  None

Surgery	Date
_____	_____
_____	_____
_____	_____
_____	_____

List all of patient's medications.  None

Medication	Dose
_____	_____
_____	_____
_____	_____
_____	_____

Who Lives at home?  Mom  Dad \_\_\_\_\_

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

\_\_\_\_\_

Allergic to medications?  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: \_\_\_\_\_