Child History Form

UF Health Pediatric Urology

Last Name ____________ First name ____________ M.I. ______

Referring Doctor ____________ Date of Birth ____________

Chief Complaint *(Reason for Visit Today)* ____________

Duration of Problem ______ Signs I Symptoms ____________

List anything that improves or worsens the problem ____________

Severity (*Circle One*): **Not Severe** 2 3 4 5 6 7 8 9 10 **Very Severe**

Doctor's notes ____________

MEDICATIONS (*currently taking*)

Name	Amount	Times / Day

LIST ANY ALLERGIES

No allergies Are you allergic to latex? ☐ Y ☐ N

Medication Allergies ☐ None

FAMILY HISTORY

		FAMILY MEMBER
Vesicoureteral reflux	☐ Y ☐ N	
Kidney disease	☐ Y ☐ N	
Nighttime wetting	☐ Y ☐ N	
Urinary tract infection	☐ Y ☐ N	
Kidney failure	☐ Y ☐ N	
Diabetes	☐ Y ☐ N	
Kidney stones	☐ Y ☐ N	
Anesthesia problems	☐ Y ☐ N	
Cancer	☐ Y ☐ N	

CHILD'S MEDICAL HISTORY

Cerebral palsy	☐ Y ☐ N	Asthma	☐ Y ☐ N
Prenatal hydronephrosis	☐ Y ☐ N	Urinary tract infections	☐ Y ☐ N
Heart murmur	☐ Y ☐ N	Constipation	☐ Y ☐ N
Developmental delay	☐ Y ☐ N	Hyper tension	☐ Y ☐ N
Seizure disorder	☐ Y ☐ N	Spina Bifida	☐ Y ☐ N
Bleeding disorder	☐ Y ☐ N	VP shunt	☐ Y ☐ N
Hepatitis	☐ Y ☐ N	Other: ______	
Cancer	☐ Y ☐ N		
Type: ______			

LIST OF ANY PAST SURGERIES /HOSPITALIZATIONS

Type	Year

SOCIAL HISTORY

History of abuse ☐ Y ☐ N

Special diet ☐ Y ☐ N

Describe ____________

Special; needs (*Wheelchair, braces, etc.*) ☐ Y ☐ N

List ____________

Age of toilet training ______

With whom does child live? ____________

Patient Name: Patient Identification #:

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Review of the systems

Does your child now, or has your child had any problems related to the following systems? (*Check yes or no)*

CONSTITUTIONAL

- Fever ☐ Y ☐ N
- Chills ☐ Y ☐ N
- Headache ☐ Y ☐ N
- Abnormal development ☐ Y ☐ N

EYES

- Blurry vision ☐ Y ☐ N
- Redness ☐ Y ☐ N

Date of most recent eye exam: ______________________

Name of eye doctor: ______________________

ALLERGIC / IMMUNOLOGIC

- Hay fever ☐ Y ☐ N
- Drug allergies ☐ Y ☐ N
- Food allergies ☐ Y ☐ N

NEUROLOGIC

- Tremor ☐ Y ☐ N
- Coordination problems ☐ Y ☐ N
- Abnormal walk ☐ Y ☐ N
- Confusion ☐ Y ☐ N
- Numbness ☐ Y ☐ N
- Tingling ☐ Y ☐ N

EARS NOSE THROAT

- Ear infection ☐ Y ☐ N
- Sore throat ☐ Y ☐ N
- Sinus problems ☐ Y ☐ N

GASTROINTESTINAL

- Abdominal pain ☐ Y ☐ N
- Nausea / vomiting ☐ Y ☐ N
- Stool incontinence ☐ Y ☐ N
- Constipation ☐ Y ☐ N
- Blood in stool ☐ Y ☐ N

CARDIOVASCULAR

- Heart murmur ☐ Y ☐ N
- Hugh blood pressure ☐ Y ☐ N
- Chest pain ☐ Y ☐ N

INTEGUMENTARY

- Skin rash ☐ Y ☐ N
- Persistent itching ☐ Y ☐ N
- Easy bruising ☐ Y ☐ N

MUSCULOSKELETAL

- Joint pain ☐ Y ☐ N
- Neck pain ☐ Y ☐ N
- Back pain ☐ Y ☐ N
- Muscle pain ☐ Y ☐ N

RESPIRATORY

- Wheezing ☐ Y ☐ N
- Frequent cough ☐ Y ☐ N
- Shortness of breath ☐ Y ☐ N

ENDOCRINE

- Excessive thirst ☐ Y ☐ N
- Too hot / cold ☐ Y ☐ N
- Tires / sluggish ☐ Y ☐ N
- Abnormal hair growth ☐ Y ☐ N

GENITOURINARY

- Painful urination ☐ Y ☐ N
- Bloody urine / underwear ☐ Y ☐ N
- Urinary retention ☐ Y ☐ N
- Frequent urination ☐ Y ☐ N
- Urgency to urinate ☐ Y ☐ N
- Daytime wetting ☐ Y ☐ N
- Nighttime wetting ☐ Y ☐ N

HEMATOLOGIC / LYMPHATIC

- Swollen lymph gland ☐ Y ☐ N
- Blood clotting issues ☐ Y ☐ N

PSYCHIATRIC

- Anxiety ☐ Y ☐ N
- Depression ☐ Y ☐ N

HAS YOUR CHILD HAD ANY X-RAYS?

Type of x-ray	Date	Hospital

Does your child have any siblings?

Names	Age

Does your child have any other medical problem about which we should know? (*please list below*)

____

____

____

Physician ______________________ Date ____________ Time ________

Patient Name: Patient Identification #:

Child History Form – Urology *(page 2 of 2)*

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