Patient Name: ________________________________ Date of Birth: ___________ Date Completed: ______________

Check All Symptoms

GENITOURINARY
__ Pain with urination
__ Difficulty urinating
__ Daytime urinary accidents
__ Urinary frequency
__ Urinary urgency
__ Foul smelling urine
__ Recurrent urinary tract Infections
__ Blood in urine
__ Vaginal redness/itching
__ Bedwetting
__ Stomach aches
__ Back pain
__ Catheterizes for urine
__ Evaluation of the foreskin
__ Foreskin infections
__ Penile adhesions
__ Deviated urinary stream
__ Small urinary opening
__ Labial adhesions

__ Undescended testicle
  __ Right __ Left
__ Scrotal swelling
  __ Right __ Left
__ Scrotal pain
  __ Right __ Left
__ Hypospadias

GASTROINTESTINAL
Stool frequency & consistency:
(Please check all that apply)
__ Hard Balls __ Daily
__ Firm __ Every 2-3 days
__ Soft
__ Loose __ A couple Times/week
__ Pain with bowel movements
__ Stools in underwear
__ GI Reflux/Heartburn

SOCIAL HISTORY
Patient live with:
__ Mom __ Sister
__ Dad __ Brother
__ Other __________________

HEART
__ **NONE**
__ Murmur
  __ Currently
  __ In the past

HEME
__ **NONE**
__ Bleeding problems
__ Sickle Cell Anemia
__ Von Willebrands
__ Iron deficient anemia
__ Bruising

LUNGS
__ **NONE**
__ Asthma
__ Cough
__ Difficulty breathing
__ Croup/Bronchiolitis
__ Pneumonia
__ Wheezing

ENDOCRINE
__ **NONE**
__ Diabetes
  __ Insulin dependent
  __ Non-insulin dependent
__ Thyroid disorder
  __ High
  __ Low

EYES __ **NONE**
__ Glasses
__ Vision changes/blurriness

MUSCULOSKELETAL
__ **NONE**
__ Joint pain/swelling
__ Muscle weakness

If the patient is 13+ year old please answer the following:
Has the patient ever smoked?
__ Yes, currently
__ Yes, in the past
__ No

NEUROLOGICAL
__ **NONE**
__ ADD / ADHD
__ Anxiety
__ Autism
__ Behavior Problems
__ Bipolar
__ Cerebral Palsy
__ Depression
__ Developmental delays
__ Headaches
__ Head/brain injury
__ Post traumatic stress
__ Seizures
__ Social Problems
__ Spina Bifida
__ VP Shunt
__ Other: __________________

SKIN
__ **NONE**
__ Dry Skin
__ Eczema
__ Flushing
__ Rashes

SLEEP
__ **NONE**
__ Sound sleeper
__ Snoring
__ Frequent night awakenings

ALLERGY
__ **NONE KNOWN**
__ Foods
__ Latex
__ Medications: _____________
__ Other (list): ______________

PHARMACY
Name:____________________
Phone: ___________________
Address:__________________
PEDIATRICIAN
Name: ___________________
Phone: ___________________

I verify that I have reviewed this document and its contents and no other additions are necessary.

Parent Signature: ____________________________ Reviewed by: _____________________________ Date: ______________