Rady Children's Hospital San Diego

**Care Team 4 – Urology**
**Rady Children's Hospital – San Diego**
3020 Children's Way
San Diego, CA. 92123

DTF718

PATIENT INFORMATION

Name: ____________________
MR#: ____________ Finance: __________
DOB: ____________________
MD: ________________

# New Patient Medical History

***To assist us in caring for your child, please complete the following questionnaire.***

**Patient Name: ________________________________ Date of Birth: __________**

| *Why are you here today?* |
|---|
| |

| *What has been done thus far for this problem?* | | | | |
|---|---|---|---|---|
| **Lab Tests** | No | Yes | Which ones? | When? |
| **X-Rays** | No | Yes | Which ones? | When? |
| **Ultrasound** | No | Yes | Which ones? | When? |
| **MRI, CT** | No | Yes | Which ones? | When? |
| **VCUG** | No | Yes | | When? |
| **Medicine for urine/kidney infection or wetting?** | No | Yes | What? | When? |
| **Any remedies tried for infection or wetting?** | No | Yes | What? | When? |

## UROLOGY HISTORY

| *Has the patient experienced any of the following symptoms? Please circle the correct answer.* | | | | | |
|---|---|---|---|---|---|
| **Infections** Bladder / Kidney | No | Yes | When did they start? | Last infection? | |
| **With fever** | No | Yes | How many? | Highest temp? | |
| **Hospitalization necessary** | No | Yes | When? | Where? | |
| **Blood in urine** | No | Yes | How many times has this occurred? | | |
| **Seen in urine test** | No | Yes | | | |
| **Seen visibly** | No | Yes | | | |
| **Dribbles or leaks urine** | No | Yes | Rarely | Occasionally | Frequently |
| **Frequently urinates** | No | Yes | Rarely | Occasionally | Frequently |
| **Pain when urinating** | No | Yes | Rarely | Occasionally | Frequently |
| **Sudden urge(s) to urinate** | No | Yes | Rarely | Occasionally | Frequently |
| **Squats/ grabs crotch to stop wetting** | No | Yes | Rarely | Occasionally | Frequently |
| **Constipation problems** | No | Yes | Rarely | Occasionally | Frequently |
| **Stool stains in pants** | No | Yes | Rarely | Occasionally | Frequently |
| **Potty trained** | No | Yes | What age? | | |
| **Problems with toilet training** | No | Yes | Please explain: | | |
| **Gets up at night to urinate** | No | Yes | Rarely | Occasionally | Frequently |
| **Wets the bed** | No | Yes | Rarely | Occasionally | Frequently |
| **Wears Pull-ups at night** | No | Yes | | | |
| **Dry nights for a long period** | No | Yes | How long did it last? | | |

## HISTORY of PATIENT'S BIRTH HISTORY

| | | | |
|---|---|---|---|
| **Mother's pregnancy with patient was** | Full Term | Ended early, @ ________wks. Gestation | |
| **Delivery was** | Vaginal | Scheduled C-section | Emergency C-section |
| **Complicated pregnancy or delivery?** | No | Yes | Please explain: |
| **Medications taken while pregnant?** | No | Yes | What? |

## PAST MEDICAL HISTORY

| | | | | |
|---|---|---|---|---|
| **Hospitalizations** | No | Yes | Why? | When? |
| **Surgeries** | No | Yes | Why? | When? |
| **Blood Transfusions** | No | Yes | When? | |
| **Contagious Diseases** | No | Yes | What? | |
| **Psychological Care** | No | Yes | Why? | When? |
| **Is child still receiving psychological care** | No | Yes | By whom? | |

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# New Patient Medical History (continued)

**Patient Name:** ____________________________________________ **Date of Birth:** ___________

### MENSTRUATING TEENAGE GIRLS ONLY

| Age when got first period? | | | | |
|---|---|---|---|---|
| How often does pt. get her period? | | | | |
| How long do periods usually last? | | | | |
| What is her flow like? | Light | Average | Heavy | Irregular |

### CHILDS FAMILY HISTORY

| ***Has any blood-related parent, sibling, grandparent, aunt, uncle or cousin of the patient had problems concerning:*** | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Anesthesia** | No | Yes | Who? | Deceased? | No | Yes | Age |
| **Asthma** | No | Yes | Who? | Deceased? | No | Yes | Age |
| **Bleeding** | No | Yes | Who? | Deceased? | No | Yes | Age |
| **Cancer** | No | Yes | Who? | Deceased? | No | Yes | Age |
| **Developmental delays** | No | Yes | Who? | Deceased? | No | Yes | Age |
| **Diabetes** | No | Yes | Who? | Deceased? | No | Yes | Age |
| **Heart Disease** | No | Yes | Who? | Deceased? | No | Yes | Age |
| **Liver or kidney Disease** | No | Yes | Who? | Deceased? | No | Yes | Age |
| **Seizures** | No | Yes | Who? | Deceased? | No | Yes | Age |
| **Tuberculosis** | No | Yes | Who? | Deceased? | No | Yes | Age |
| **Bedwetting** | No | Yes | Who? | Until what age? | | | |

### SIGNIFICANT FAMILY MEDICAL HISTORY (especially urology issues)

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

### SOCIAL HISTORY

| ***Patient's parents are:*** | Married | Unmarried | Divorced | Separated | Widowed (One parent is deceased) |
|---|---|---|---|---|---|
| ***Who does patient live with?*** | | | | | |

| If *not* blood-related, please specify. (For example; a step, or adopted brother or sister.) | **Brother(s) / Age** | **Sister(s) / Age** | **Condition of Health** |
|---|---|---|---|
| | ____________ | ____________ | ____________ |
| | ____________ | ____________ | ____________ |
| | ____________ | ____________ | ____________ |

| | | | |
|---|---|---|---|
| **Attends school** | No | Yes | **Grade:** |
| **School performance** | Good | Poor | |
| **Learning disabilities** | No | Yes | What type? |
| **Attends after-school program** | No | Yes | |
| **Extracurricular activities** | No | Yes | What type? |
| **Experiencing new changes or stresses** | No | Yes | Explain: |

### IMMUNIZATIONS

| Diptheria, Tetanus and Pertusis | No | Yes | Date |
|---|---|---|---|
| Polio | No | Yes | Date |
| Hepatitis B1 | No | Yes | Date |
| Hepatitis B2 | No | Yes | Date |
| Hepatitis B3 | No | Yes | Date |
| Hib | No | Yes | Date |
| Measles, Mumps, Rubella | No | Yes | Date |
| Varicella (Chicken Pox) | No | Yes | Date |
| | | | |

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# New Patient Medical History (continued)

**Patient Name:** ________________________________________ **Date of Birth:** ___________

## ALLERGIES

| | | | |
|---|---|---|---|
| **Latex** | No | Yes | |
| **Food(s)** | No | Yes | |
| **Other Substances** | No | Yes | |
| **Medications** | No | Yes | **Which Medications?** |

## CURRENT MEDICATIONS

| Medication and dose | Homeopathic or Natural Remedies |
|---|---|
| 1. ______________________ | 1. ______________________ |
| 2. ______________________ | 2. ______________________ |
| 3. ______________________ | 3. ______________________ |
| 4. ______________________ | 4. ______________________ |

## REVIEW OF SYSTEMS

| ***Has the patient had any problems with:*** | | | | | |
|---|---|---|---|---|---|
| **HEENT (head/eyes/ears/throat)** | | | **Musculoskeletal (muscle and bone)** | | |
| Headaches | No | Yes | Muscles | No | Yes |
| Eyes | No | Yes | Bones | No | Yes |
| Ears | No | Yes | Arms | No | Yes |
| Nose | No | Yes | Legs | No | Yes |
| Swollen glands | No | Yes | Hips | No | Yes |
| Sinus problems | No | Yes | Back | No | Yes |
| **Pulmonary (lungs)** | | | Feet | No | Yes |
| Asthma/Wheezing | No | Yes | **Hematalogic/Lymph (blood)** | | |
| Persistent Cough | No | Yes | Clotting problems | No | Yes |
| Shortness of Breath | No | Yes | Bleeding problems | No | Yes |
| **Cardiac (heart)** | | | Bruising easily | No | Yes |
| Heart defect(s) | No | Yes | **Neurologic (nervous system)** | | |
| Skin turning blue | No | Yes | Head Injury | No | Yes |
| Heart murmur(s) | No | Yes | Seizures | No | Yes |
| Palpitations | No | Yes | **Psychological** | | |
| **GI (digestive system)** | | | Depression | No | Yes |
| Stomach | No | Yes | Anxiety/nervousness | No | Yes |
| Constipation | No | Yes | Sleep disorder | No | Yes |
| Diarrhea | No | Yes | **Integument (skin)** | | |
| Nausea / Vomiting | No | Yes | Poor wound healing | No | Yes |
| | | | Rashes | No | Yes |
| **Endocrine (hormonal system)** | | | | | |
| Excessive appetite | No | Yes | Weight problem | No | Yes |
| Excessive thirst | No | Yes | Cold / heat intolerance | No | Yes |

| **CONTACT INFORMATION** | **Father** | **Mother** |
|---|---|---|
| **Place of Employment** | | |
| **Occupation** | | |
| **Phone Number(s)** | **Work:** | **Work:** |
| | **Home:** | **Home:** |
| | **Other:** | **Other:** |

Name of Person Filling out Form: ________________________________ Date: __________

Relationship to Patient: ____________________

Physician Signature: ________________________________________ Date: __________