Patient & Family History

Children's Urology
of the Carolinas

Reason for visit: _____

When did the problem begin? _____

What Tests/ X-rays have been done? _____

Current Medications & Dose (list all prescription, non-prescription & natural medications):

_____

_____

Allergies (medicines, latex, tape, dyes, etc): _____

_____

Birth History

Full-term___ Premature___ (# of weeks premature_____)
Birth Weight___ Birth Hospital _____ Birth City & State _____
Complications with pregnancy or delivery _____

Patient's Medical History (check if the child or adolescent has been diagnosed with the following):

- ADD___
- ADHD___
- Allergies (environmental)___
- Anemia___
- Anesthesia Problems___
- Asthma___
- Arthritis___
- Birth Defects___
- Bleeding Disorders___
- Bone Problems___
- Cancer___
- Cerebral Palsy___
- Cholesterol Problems___
- Cystic Fibrosis___
- Constipation (chronic)___
- Diabetes___
- Downs Syndrome___
- Hearing Impairment___
- Heart Problems___
- Heart Murmurs___
- High Blood Pressure___
- HIV/ AIDS___
- Immune Problems___
- Learning Problems___
- Liver Problems___
- Lung Problems___
- Measles___
- Migraine Headaches___
- Muscle Problems___
- Psoriasis___
- Seizures___
- Sickle Cell Disease___
- Sickle Cell Trait___
- Sinus Problems___
- Skin Problems___
- Speech Problems___
- Spina Bifida___
- Stomach Ulcers___
- Stomach Reflux___
- Strep Throat___
- Thyroid Problems___
- Tracheomalacia___

Any other specific medical history of patient? _____

_____

Patient's Name _____ **DOB** _____

Patient's Hospitalizations (dates & reasons)_____

_____

Patient's Previous Surgeries (include ear tubes)_____

_____

_____

Family History (check if there is a family history of the following– including patient's natural parents, brothers, sisters, aunts, uncles and grandparents only):

- Anemia___
- Anesthesia Problems___
- Asthma___
- Arthritis___
- Bedwetting___
- Birth Defects___
- Bleeding Disorders___
- Cancer___
- Cerebral Palsy___
- Cholesterol Problems___
- Cystic Fibrosis___
- Diabetes___
- Downs Syndrome___
- Gastrointestinal Problems___
- Heart Problems___
- High Blood Pressure___
- HIV/ AIDS___
- Kidney Problems___
- Liver Problems___
- Lung Problems___
- Seizures___
- Sickle Cell Disease___
- Sickle Cell Trait___
- Skin Problems___
- Spina Bifida___
- Thyroid Problems___

How many biological brothers does patient have?_____ (list ages: _____)

How many biological sisters does patient have?_____ (list ages: _____)

Social History (please check where appropriate): Patient's School Grade: _____

Parents are: married___ divorced___ separated___ single___

Patient lives with: biological parents___ adopting parents___ guardian___

foster care___ mother___

Mother's place of birth _____ Father's place of birth_____

Patient's Urinary History (check where appropriate):

Bedwetting___ Day Wetting___

Urinary frequency is normal___ increased___ decreased___

Wakes-up at night to urinate 0-1 x per night___ 2-4 x per night___ >4 x per night___

Urine is not bloody___ Visibly bloody urine___ Informed of blood in urine by doctor only___

Chronic Constipation___ Accidents or soiling of stool___ Chronic diarrhea___

Burning with urination___ Deviated Urinary Stream___

Urine Infections___ Genital Pain___ Kidney Stones___