MR#: ☐☐☐☐☐☐☐

Name of Patient:

Date of Birth:

Place Label Here

UNIVERSITY OF CALIFORNIA, DAVIS
MEDICAL CENTER
SACRAMENTO, CALIFORNIA

UROLOGY CLINIC
PEDIATRIC PATIENT QUESTIONNAIRE

Consultation requested by: (Pediatrician Name and address):_____

_____

Did someone other than your Pediatrician send you to our office? (i.e. Urologist)_____

_____

Why was your child sent to a Pediatric Urologist?_____

_____

Has your child ever had any of the following symptoms?

Abdominal Pain	❒ Yes ❒ No	Urine Frequency	❒ Yes ❒ No
Pain on Urination	❒ Yes ❒ No	Holds Urine over 4 hours	❒ Yes ❒ No
Difficulty with Urination	❒ Yes ❒ No	Blood in Urine	❒ Yes ❒ No
Daytime Wetting	❒ Yes ❒ No	Constipation	❒ Yes ❒ No
Bed Wetting	❒ Yes ❒ No	Stool Incontinence	❒ Yes ❒ No

If you answer "Yes" to any of the above questions, please explain:_____

_____

BIRTH HISTORY

Was your child born premature? ❒ Yes ❒ No _____Weeks Early
Was there any complication with the birth? ❒ Yes ❒ No _____
Do you remember your child's birth weight? ❒ Yes ❒ No _____ lbs. _____ Ounces
Did you have abnormal prenatal ultrasounds? ❒ Yes ❒ No _____

MEDICAL HISTORY

Does your child have any medical problems?

Migraines	❒ Yes ❒ No	Diabetes	❒ Yes ❒ No	Gastroesophageal Reflux	❒ Yes ❒ No
Seizures	❒ Yes ❒ No	Kidney Stones	❒ Yes ❒ No	Heart Problems (murmurs)	❒ Yes ❒ No
Asthma	❒ Yes ❒ No	Ear Infections	❒ Yes ❒ No	Other:	_____

Has your child had any surgeries? ❒ Yes ❒ No_____

MEDICATIONS: Does your child take any medications? ❒ Yes ❒ No _____
ALLERGIES: Does your child have any allergies to any medications? ❒ Yes ❒ No _____

FAMILY AND SOCIAL HISTORY

Has anybody in the family had similar medical problems as your child? ❒ Yes ❒ No _____
Who lives at home with your child? (Please specify ages and relationship)

Mother ❒ Yes ❒ No Father ❒ Yes ❒ No Brother ❒ Yes ❒ No Sister ❒ Yes ❒ No
Other(s) _____

REVIEW OF SYSTEMS

Is your child having any of the following symptoms?

Fever	❒ Yes ❒ No	Vision Impairment	❒ Yes ❒ No	Ear pain	❒ Yes ❒ No
Fatigue	❒ Yes ❒ No	Shortness of Breath	❒ Yes ❒ No	Nausea	❒ Yes ❒ No
Weight Loss	❒ Yes ❒ No	Wheezing	❒ Yes ❒ No	Dizziness	❒ Yes ❒ No
Loss of Appetite	❒ Yes ❒ No	Rash	❒ Yes ❒ No	Paralysis	❒ Yes ❒ No
Bleeding Gums	❒ Yes ❒ No				

Patient Signature_____ Date _____ Physician's Initials _____

Form completed by: ❒ **Patient** ❒ **Parent** ❒ **Guardian** ❒ **Care Taker**