

ADULT & PEDIATRIC
Urology Group

The doctors' choice for quality patient care.

FIRST NAME: _____ **LAST NAME:** _____ **TODAY'S DATE:** ____/____/____
Date of Birth: ____/____/____

CHIEF COMPLAINT:

What is the reason for your child's visit today? _____

Where is this problem located? _____

When did you (or the child) first notice this problem? _____ How long does the problem last? _____

Does anything make the problem worse? No Yes If **yes**, please explain: _____

Does this interfere with your child's normal functions? No Yes If **yes**, please explain: _____

MEDICAL HISTORY: Please check all illnesses that apply

Personal Illnesses (patient)

- Asthma Arthritis Cancer Diabetes
Heart Disease High Blood Pressure
Kidney Stones Thyroid Problems Other: _____

Family Illnesses (grandparents, parents, or siblings)

- Asthma Arthritis Cancer Diabetes
Heart Disease High Blood Pressure
Kidney Stones Thyroid Problems Other: _____

Please explain any illnesses: _____

Please list all medications your child is currently taking: _____

Is your child on a special diet? No Yes If **yes**, please describe: _____

Does your child have allergies to any medications? No Yes If **yes**, please list: _____

Has your child had any surgeries? No Yes If **yes**, please explain what kind and when _____

When you were pregnant with this child: What was the length of the pregnancy? _____

Was the pregnancy Normal or Abnormal? If **abnormal**, describe: _____

If you had a pregnancy ultrasound, was it Normal or Abnormal?

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REVIEW OF SYSTEMS: "Vq"cmqy "wu"vq'r gthqto "c"vj qtqwi j "j kxqt {"r rncug"eqo r rvg'vj g'hqmjy kpi "cdrg0"J cu" {qwt "ej kf "gxgt gZr gtlgpegf "cp {"qh"vj g'hqmjy kpi "r tqdrgo u0Ej genlYgu"qt "Nq0

To elaborate, please explain any Yes answers in the space provided or on the back.

Constitutional Symptoms		Gastrointestinal		Respiratory	
Hgxgt Ej kmu J gcf cej g Qvj gtaaaaaaaaa	[""P [""P [""P	Cdf qo kpcnr clp P cwugc kqo kkp Eqpukr cvkqp Qvj gt'aaaaaaaa	[""P [""P [""P	Y j ggl kpi Hgs wgpv'eqwi j Uj qtvpguu'qh'Dtgcvj Qvj gt'aaaaaaaa	[""P [""P [""P
Eyes		Cardiovascular		Hematologic/Lymphatic	
Dnwtgf "Xkukqp F qwdrg"Xkukqp Rclp Qvj gt'aaaaaaa	[""P [""P [""P	J gctvO wto wt Qvj gt'aaaaaa	[""P [""P	Uy qmgp'i rpf u Dnqf "emwki "r tqdrgo Qvj gt'aaaaaaa	[""P [""P [""P
Allergic/Immunologic		Integumentary		Ear/Nose/Throat/Mouth	
J c {"Hgxgt F twi "Cmgti kgu Qvj gt'aaaaaaa	[""P [""P [""P	Unkp'tcu Dqlu Rgtukv'ke Qvj gt'aaaaaaa	[""P [""P [""P	Gct'kphgevkp Uqt'vj tqcv Ukpwr'tqdrgo u Qvj gt'aaaaaaaa	[""P [""P [""P
Neurological		Endocrine		Genitourinary	
Vtgo qtu F k {"Ur gmu P wo dpguu'kpi rkp Y gcnpguu Qvj gt'aaaaaa	[""P [""P [""P [""P	Gzeguukg"Vj kuv Vqq"j qv'eqrf Qvj gt'aaaaaaa	[""P [""P [""P	Wkpg'tgvpvkp Rclphwi'wtkcvkqp Wkpc {"Hgs wgpv'eqwi Wkpc {"tcev'kphgevkp Dnqf "k'wtkp F k heww' "xqk kpi P qto cnUtgco Qvj gt'aaaaa	[""P [""P [""P [""P [""P [""P [""P
		Musculoskeletal			
		Lqkpvr clp Qvj gt'aaaaaaa	[""P		

**** If needed, please utilize space on the back of this form.**

Date	Doc. Initials	Date	Doc. Initials
aaaa	aaaaaaaaa ""□ Wpej cpi gf ""□ Ej cpi g'P qvgf ""	aaaa	aaaaaaaaa ""□ Wpej cpi gf ""□ Ej cpi g'P qvgf ""
aaaa	aaaaaaaaa ""□ Wpej cpi gf ""□ Ej cpi g'P qvgf ""	aaaa	aaaaaaaaa ""□ Wpej cpi gf ""□ Ej cpi g'P qvgf ""
aaaa	aaaaaaaaa ""□ Wpej cpi gf ""□ Ej cpi g'P qvgf ""	aaaa	aaaaaaaaa ""□ Wpej cpi gf ""□ Ej cpi g'P qvgf ""
aaaa	aaaaaaaaa ""□ Wpej cpi gf ""□ Ej cpi g'P qvgf ""	aaaa	aaaaaaaaa ""□ Wpej cpi gf ""□ Ej cpi g'P qvgf ""

