Patient History Questionnaire-CSSG Children's Urology

Date: _____

Patient Name: _____

Date Of Birth _____ **Age** _____ **years,** _____**months**

Home PH _____ **Cell PH** _____

E-Mail Address _____

Primary Care Physician (PCP_ _____

PCP's Address _____

PCP's Phone Number (_____**)**_____

_____

Name of person filling out of form: _____ Relationship to patient: _____

Patient Accompanied By: _____

What problem would you like us to evaluate today: _____

Exposure within last 30 days: (circle) Measles Mumps Chicken Pox Tuberculosis Resistant Bacteria None Other: _____

Prior Injuries: _ No _ Yes (please state type of injury , date and treatment): _____

Prior X-rays: _ No _ Yes (please state type of x-ray and date): _____

Prior Illnesses: _ No _ Yes (please state illness, dates, treatment and duration): _____

Prior Surgeries _ No _ Yes (please state type of surgery and date):_____

Current Injury Date: _____ External cause of injury: _____

Urological System History (specific intake):

Age child toilet trained during daytime: _____

Currently during the daytime:
Child is in ☐Underwear ☐ Pullup ☐ Diaper

Daytime child currently is:

Completely dry ○ Yes ○ No

Occasionally moist ○ Yes ○ No

Damp underwear ○ Yes ○ No

Soaks outer clothes ○ Yes ○ No

Puddle of urine on ground ○ Yes ○ No

Age child toilet trained during nighttime: _____

Currently during the nighttime
Child is in ☐Underwear ☐ Pullup ☐ Diaper

Nighttime child currently is:

Completely dry ○ Yes ○ No
If not dry, how many nights per average week does child wet the bed? _____ /week

Child wakes up after wetting the bed ○ Yes ○ No

Child gets up at night to urinate ○ Yes ○ No
If yes, how many times per night _____

Child snores at night ○ Yes ○ No

Child has sleep apnea ○ Yes ○ No

Daytime Voiding Symptoms (check all that apply)

☐ Difficulty getting urine stream started	☐ Urinary urgency (gotta go!)
☐ Weak or poor urine stream	☐ Urinary frequency (>8 voids/day)
☐ Intermittent urine stream (stop, go, stop, go)	☐ Urinary infrequency (<3 voids/day)
☐ Pushing or straining to urinate, pee, void	☐ Urinary dancing/squatting/posturing
☐ Feelings of not completely emptying bladder	☐ Dysuria (hurts to pee)
☐ Delays voiding until last minute	
☐ Staccato (bursts) voiding	
Voids ☐ Small ☐ Large Amount ☐ Just right	

Bowel Habits

How often does child poop? _____ times per ☐ day ☐ week

Does child have:

Poop accidents in underwear ○ Yes ○ No

Hard/chunky poop ○ Yes ○ No

Poop soiling of underwear ○ Yes ○ No

Plug toilet with poop ○ Yes ○ No

Pain with pooping ○ Yes ○ No

Has child had any Urinary Tract (Bladder/Kidney) Infections? ○ Yes ○ No

If yes, when, how often, and how treated?

_____

Additional comments regarding child's problem:

_____

Current Medications: _____

_____

Allergies:

Allergies to Medications? _ No _ Yes (please list medication and reaction to that medication!)

_____

Allergies to Food and Environmental? _ No _ Yes (please list reaction) _____

Allergies to Latex? _ No _ Precautions Only _ Yes (explain reaction) _____

Allergies to Metal Objects? _ No _ Yes (please list with reaction) _____

Past Medical History/Problems/Surgeries/Hospitalizations: _____

_____

School Information:

Name of School:_____ Current grade: _____

Social History:

Hobbies/Sports/Activities: _____

Who lives in the home: _____

Developmental Milestones:

Rolling Over: _ No _ Yes, age: __

Sitting Up: _ No _ Yes, age: __

Crawling: _ No _ Yes, age: __

Walking: _ No _ Yes, age: __

Overall assessment: __ Within Normal Limits

__ Not Answered

__ Declined

Birth History:

Prenatal issues: _____

Was the pregnancy full term? _ No _ Yes

If no, number of weeks or months _____

Mode of Delivery: _ Vaginal _ C-section

Position: _ Vertex _ Breech

Any complications with the delivery? _ No _ Yes

If yes, explain _____

Birth Weight: _____ Comments: _____

Length at Birth: _____

Any complications during the newborn period? _ No _ Yes

If yes, explain _____

Is your child adopted? _ No _ Yes

Does your child have an identical twin? _ No _ Yes

Adolescent Health:

Menarche Onset: _____ Last Menstrual Period: _____

Sexually active? _ No _ Yes _ Unknown

Types of Contraception/Protection?_____

Family History

Please identify family medical history.

Illness	Mother	Father	Sister	Brother	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Deceased								
- Deceased Cause								
Asthma								
Bladder Cancer								
Bleeding Disorders								
Epispadias								
Exstrophy								
Fetal Renal Anomaly								
Heart Disease								
Hernia								
Hydrocele								
Hydronephrosis								
Hydroureter								
Hypospadias								
Kidney Carcinoma								
Kidney Disease								
Kidney Stones								
Megaureter								
Multicystic dysplastic kidney								
Neurogenic Bladder								
Renal Aplasia								
Sickle Cell Disease								
Spina Bifida								
Surgery								
Testicular Cancer								
Tuberous Sclerosis								
Undescended testicle								
Ureterocele								
Vesicoureteral Reflux								
Wilms Tumor								

PATIENT REVIEW OF SYSTEMS:

SYSTEM	PLEASE CHECK ALL THAT APPLY
GENERAL	o **NONE** o Fatigue o Fever o Chills o Sweats o Change in Appetite o Fainting o Change in Sleep Habits o Weight Loss o Weight Gain o Bleeding Problems
HEAD	o **NONE** o Headaches o Recent Trauma
EYES	o **NONE** o Decreased Vision o Pain o Itch o Dryness o Redness o Infection o Glaucoma o Double Vision o Glasses o Contact Lenses
EARS	o **NONE** o Decreased Hearing o Deafness o Discharge o Pain o Ringing o Dizziness
NOSE & SINUSES	o **NONE** o Decreased Sense of Smell o Bleeding o Dryness o Pain o Discharge o Obstruction o Sinusitis o Seasonal Allergies
THROAT & MOUTH	o **NONE** o Sore Throat o Pain o Infection o Sore Tongue o Ulcers o Blisters o Lip Lesions o Canker Sores o Difficulty Swallowing o Hoarseness o Tonsillitis o Problems with Teeth
NECK	o **NONE** o Stiffness o Decreased Motion o Pain o Lumps o Swollen Glands
BREASTS	o **NONE** o Discharge o Bleeding o Retraction o Tenderness o Size
SKIN	o **NONE** o Rash o Itch o Color Change o Moles/Changes o Infections o Hair/Changes o Nails/Changes o Tumors o Sores o Hives
RESPIRATORY	o **NONE** o Cough o Chest Pain o Wheezing o Asthma o Pneumonia o Sputum (Color/Frequency) o Recurrent Infection o Exposure to Tuberculosis o Cyanosis (bluish tint to skin, lips, nails) o Shortness of Breath on Exercise
CARDIOVASCULAR	o **NONE** o Chest Pain o Murmur o Palpitations o Shortness of Breath o Difficulty Breathing o Fainting o Phlebitis o Varicose Veins
LYMPHATIC	o **NONE** o Anemia o Bleeding o Malignancy o Swollen Lymph Nodes o Transfusions
GASTROINTESTINAL	o **NONE** o Nausea o Vomiting o Vomiting Blood o Diarrhea o Heartburn o Food Intolerance o Change in Bowel Habits o Hernia o Constipation o Laxative/Enema Use o History of Ulcers o Abdominal Pain o Belching o Black Stools o Blood in Stools o Stooling "Accidents" o Bloating o Hemorrhoids o Nutritional Concerns_____
GENITOURINARY	o **NONE** o Burning o Inability to Start Stream o Infection o Urgency o Blood in Urine o Incontinence o Kidney Stones o Bedwetting o Daytime Urinary Leakage o Urinating Less Often o Urinating More Often o Toilet Trained, at what age _____
MALE REPRODUCTIVE	o **NONE** o CIRCUMCISED o Pain o Skin Lesions o Impotence o Testicular Pain o History of Sexually Transmitted Diseases
FEMALE REPRODUCTIVE	o **NONE** o Discharge o Itch o Infection o Started Menstrual Cycle o Painful Menstrual Cramps o Contraceptive Use o Complication of Pregnancy o History of Sexually Transmitted Diseases o Childbirth o Abortion o Painful Intercourse
MUSCULOSKELETAL	o **NONE** o Muscle Cramps o Pain o Weakness o Atrophy o Swelling o Joint Pain o Fracture o Back Injury o Curvature of Spine
ENDOCRINE & METABOLIC	o **NONE** o Heat or Cold Intolerance o Weight Change o Diabetes o Hair Change o Excessive Sweating o Urinary Frequency o Voice Change o Excessive Thirst
NEUROLOGIC	o **NONE** o Headache o Fainting o Seizures o Dizziness o Blindness o Double Vision o Paralysis o Tremor o Pain o Numbness o Tic o Tingling Sensation o Burning Sensation o Lack of Coordination
PSYCHIATRIC & EMOTIONAL	o **NONE** o Anxiety o Sleep Disturbances o Depression o Nervousness o Tension o Thoughts of Suicide o Emotional Instability o Delusions o Memory Loss o Hallucinations