University of Florida
Pediatric Urology

Child History Form

Last Name _____ First name _____ M.I. _____

Referring Doctor _____ Date of Birth _____

Chief Complaint (Reason for Visit Today) _____

Duration of Problem _____ Signs / Symptoms _____

List anything that improves or worsens the problem _____

Severity (Circle One): not Severe 1 2 3 4 5 6 7 8 9 10 Very Severe

Doctor's notes _____

MEDICATIONS
(currently taking)

Name	Amount	Times / Day

CHILD'S MEDICAL HISTORY

Cerebral Palsy	y	n	Asthma	y	n
Prenatal Hydronephrosis	y	n	Urinary Tract Infections	y	n
Heart Murmur	y	n	Constipation	y	n
Developmental Delay	y	n	Hyper Tension	y	n
Seizure Disorder	y	n	Spina Bifida	y	n
Bleeding Disorder	y	n	VP Shunt	y	n
Hepatitis	y	n	Other		
Cancer	y	n	_____		
TYPE _____			_____		

LIST ANY ALLERGIES

No Allergies Are You Allergic to Latex? Y N

Medication Allergies ☐ None

LIST OF ANY PAST SURGERIES/HOSPITALIZATIONS

Type	Year

FAMILY HISTOY

			FAMILY MEMBER
Vesicoureteral Reflux	y	n	
Kidney Disease	y	n	
Nighttime Wetting	y	n	
Urinary Tract Infection	y	n	
Kidney Failure	y	n	
Diabetes	y	n	
Kidney Stones	y	n	
Anesthesia Problems	y	n	
Cancer	y	n	

SOCIAL HISTOY

History of abuse y n

Special Diet y n

Describe _____

Special needs (wheelchair, braces, etc.) y n

List _____

Age of Toilet Training _____

With whom does the child live?

_____

_____

Review of systems

Does your child now, or has your child had any problems related to the following systems? Circle yes or no.

CONSTITUTIONAL

Fever	y / n
Chills	y / n
Headache	y / n
Abnormal Development	y / n

EYES

Blurry Vision	y / n
Redness	y / n

Date of Most Recent Eye Exam: _____

Name of Eye Doctor: _____

ALLERGIC/IMMUNOLOGIC

Hay Fever	y / n
Drug allergies	y / n
Food allergies	y / n

NEURLOGIC

Tremor	y / n
Coordination Problems	y / n
Abnormal Walk	y / n
Confusion	y / n
numbness	y / n
Tingling	y / n

EARS, NOSE, THROAT

Ear Infection	y / n
Sore Throat	y / n
Sinus Problems	y / n

GASTROINTESTINAL

Abdominal Pain	y / n
Nausea / Vomiting	y / n
Stool incontinence	y / n
Constipation	y / n
Blood in Stool	y / n

CARDIOVASCULAR

Heart Murmur	y / n
High Blood Pressure	y / n
Chest Pain	y / n

INTEGUMENTARY

Skin Rash	y / n
Persistent itching	y / n
Easy Bruising	y / n

MUSCULOSKELETAL

Joint Pain	y / n
Neck Pain	y / n
Back Pain	y / n
Muscle Pain	y / n

RESPIRATORY

Wheezing	y / n
Frequent Cough	y / n
Shortness of Breath	y / n

ENDOCRINE

Excessive Thirst	y / n
Too Hot / Cold	y / n
Tired / Sluggish	y / n
abnormal Hair growth	y / n

GENITOURINARY

Painful Urination	y / n
Bloody Urine/Underwear	y / n
Urinary Retention	y / n
Frequent urination	y / n
Urgency to Urinate	y / n
Daytime Wetting	y / n
Nighttime Wetting	y / n

HEMATOLOGIC/LYMPHATIC

Swollen Lymph Gland	y / n
Blood Clotting Issues	y / n

PSYCHIATRIC

Anxiety	y / n
Depression	y / n

HAS YOUR CHILD HAD ANY X-RAYS?

Type of X-Ray	Date	Hospital

Does Your Child Have Any Siblings?

Names	Age

Does your child have any other Medical Problem about which we should know? (Please List Below)

_____

_____

_____

Physician _____ **Date** _____