Austin:
1301 Barbara Jordan Blvd Suite 302 Austin Texas 78723

Cedar Park:
1301 Medical Parkway Suite 310 Cedar Park Texas 78613

CHILDREN'S UROLOGY

Past Medical History

Patient Name: _____

Date of Birth: _____

Medications

Please list current medications _____

_____

Allergies

Please list all known allergies (medications, foods or environmental_____

_____

Previous hospitalization(s): *symptom & Date*

_____

_____

Previous Surgeries *Procedure & Date*

_____

_____

Has your child had any blood transfusions? ❑ **no** ❑ **yes**

Has your child been circumcised? ❑ **no** ❑ **yes** When? _____

Medical Conditions/Problems

Please list any other known medical:

_____

_____

Reason for today's visit? _____

Has your child had any lab test or x-rays for this problem? NO YES

If YES which test, when and where were they performed? _____

_____

What Pharmacy do you use? _____

Location of Pharmacy: _____

Questions for Prenatal only

When is your due Date? _____ Who will be the baby's PCP?_____

Who is your Obstetrician?_____ Which Hospital will you deliver? _____

Name of the Person Completing form_____Relation to Patient _____

Signature_____Date _____

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Past Medical History

Patient Name: _____

Date of Birth: _____

Social history

Parent 1 occupation: _____

Parent 2 occupation: _____

Please list names and ages of siblings:

_____

_____

_____

Who lives in the Household? _____

Child's daytime activities

Home	NO	Yes
Daycare	NO	Yes
Recreation/Sports	NO	Yes

List sports: _____

Birth History

Illness during the pregnancy of this child:

❑ **no** ❑ **yes** Explain _____

Medications taken during pregnancy:

❑ **no** ❑ **yes** Explain _____

Delivery: ❑ **full term**

❑ **pre-term** **#weeks** _____

❑ **late**

Problems during delivery:

❑ **no** ❑ **yes** Explain _____

_____

Family history

Please list any family members (parent, sibling, grandparent, or other relatives) who have had any of these medical conditions:

Bleeding Disorder	Yes	No	If yes, relation: _____
Anesthesia Complication	Yes	No	If yes, relation: _____
Kidney Failure	Yes	No	If yes, relation: _____
Kidney Stones	Yes	No	If yes, relation: _____
UTI	Yes	No	If yes, relation: _____
Hydronephrosis "extra urine in kidney"	Yes	No	If yes, relation: _____
Hypospadias "urine opening too low"	Yes	No	If yes, relation: _____
Diabetes	Yes	No	If yes, relation: _____
Hypertension	Yes	No	If yes, relation: _____
Vesicoureteral Reflux	Yes	No	If yes, relation: _____
Other	Yes	No	If yes, relation: _____

Past Medical History

Ear/Eye Problems	No	Yes	Nose/Sinus/Throat Problems	No	Yes
Seizures	No	Yes	Headaches/Dizziness	No	Yes
Heart Problems/Murmurs	No	Yes	Asthma/Bronchitis	No	Yes
Pneumonia	No	Yes	Stomach Problems	No	Yes
Diarrhea/Constipation	No	Yes	Bleeding/Clotting Problems	No	Yes
Frequent Nosebleeds/Bruising	No	Yes	Sickle Cell disease Trait G6PD	No	Yes
Anesthesia Problems	No	Yes	Cancers	No	Yes
Diabetes	No	Yes	Behavioral/Emotional Problems	No	Yes
Developmental Problems	No	Yes	School Problems	No	Yes
Psychiatric Problems	No	Yes	Muscle/Bone Problems	No	Yes

Signature: _____ Date: _____