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CHILDREN'S UROLOGY

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CHILDRENSUROLOGY.COM

Patient's Name: _____DOB: _____

Please circle any recent symptoms your child may currently be having

CONSTITUTIONAL: Weight loss, fever, chills, weakness, tiredness, or **no symptoms**

Head and Eyes: Visual loss, blurred vision, double vision, yellow eyes, headaches, or concussions, or **no symptoms**

Ears, Nose, Throat: Hearing loss, ear infections, tonsillitis, trouble breathing, bloody noses, sneezing, congestion, runny nose or sore throat, or **no symptoms**

SKIN: Rash, itching, skin issues, or **no symptoms**

CARDIOVASCULAR: Chest pain, palpitations, swelling, cyanosis (child turns blue), or heart murmurs, or **no symptoms**

RESPIRATORY: Shortness of breath, cough, productive cough, pneumonia, bronchiolitis, wheezing, chronic cough, recent RSV, coughing up blood, TB, or asthma, or **no symptoms**

GASTROINTESTINAL: Nausea, vomiting or diarrhea, abdominal pain, blood in stool, change in stool color, constipation, jaundice (yellow color to skin), colic, loss appetite, or **no symptoms**

NEUROLOGICAL: Headaches, dizziness, fainting, paralysis, numbness, tingling in the hands or feet or **no symptoms**

MUSCULOSKELETAL: Muscle pain, back pain, joint pain, joint stiffness, joint swelling, scoliosis, muscle weakness, recent injuries, changes in walking, or **no symptoms**

HEMATOLOGIC: Anemia, abnormal bleeding or bruising, sickle cell disease/trait, G6PD disease, history of cancer, or **no symptoms**

LYMPHATICS: Enlarged lymph nodes

PSYCHIATRIC: History of depression or anxiety, ADHD, behavioral/emotional problems, or autism spectrum disorders, or **no symptoms**

ENDOCRINOLOGIC: Abnormal sweating, cold or heat intolerance, abnormal thirst, or **no symptoms**

ALLERGIES: Seasonal allergies, asthma, hives, eczema, runny nose, allergies to food

UROLOGIC REVIEW OF SYSTEMS

VOIDING: Burning when urinating, urgency with urinating, frequency with urinating, holding of urine for long periods of time, daytime wetting accidents, bed wetting, dribbling or urine, UTIs, blood in the urine, difficulty toilet training, weak urine stream, deflected urinary stream, difficulty initiating urine stream, flank pain (pain in the side and back)

For Males:

GU: Scrotal pain, testicular pain, penile pain, foreskin problems

For Females:

MENSTRUAL HISTORY

Age at start of menses_____

Number of days in menstrual cycle_____

Date of start of last menstrual period_____

Parent/Guardian Signature and Date: _____