PSYCHIATRIC: History of depression/anxiety ___ ADHD ___ Behavioral/emotional issues ___
Autism Spectrum Disorders (ASD) ___ **No symptoms** ___

ENDOCRINOLOGIC: Abnormal sweating ___ Cold or heat intolerance ___ Abnormal thirst ___
No symptoms ___

ALLERGIES: Seasonal allergies ___ Asthma ___ Hives ___ Eczema ___ Runny nose ___
Allergies to food ___ **No symptoms** ___

UROLOGIC REVIEW OF SYSTEMS

VOIDING: Burning when urinating ___ Urgency with urinating ___ Frequency with urinating ___
Holding urine for long periods of time ___ Daytime wetting accidents ___
Bed wetting ___ Dribbling of 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) ___

Males:

Genitourinary: Scrotal pain ___ Testicular pain ___ Penile pain ___ Foreskin problems ___

Females:

MENSTRUAL HISTORY

Age at start of menses __________

Number of days in menstrual cycle ________

Date of start of last menstrual period _____________

Parent/Guardian Name (Printed): ____

Parent/Guardian Signature: ____

Relationship to Patient: __________________________________ **Date:** _______________