ROCKY MOUNTAIN
PEDIATRIC UROLOGY

Date: _____ Patient: _____DOB: _____

Please explain why the patient is being seen in our office:

_____

How long has this been a concern?_____

MEDICATION: Regular or daily (include any herbals): _____
Occasional Medications: _____

ALLERGIES: Medications _____
Other (food, latex, tape, etc.) _____

BIRTH: ( ) Term ( ) Preterm How many weeks? _____ Birth Weight _____

PREVIOUS SURGERIES: _____

HOSPITALIZATIONS: (age/reason) _____

FAMILY HISTORY: Any family members with:

( ) Complications with surgery/anesthesia
( ) Kidney Problems ( ) Bladder Infections
( ) Diabetes
( ) Kidney stones/Tumors ( ) Kidney surgery
( ) Blood in urine
( ) Other

Any Brothers? _____ Any Sisters? _____ Do they have medical problems? _____

PLEASE CIRCLE ANY OF THE FOLLOWING THAT MAY APPLY TO PATIENT:

( ) **BLADDER:** Difficulty starting a stream, weak stream, interrupted stream, poor aim, daytime accidents, bedwetting, bladder infections (with fever)
How many times per day does the patient empty the bladder? _____

( ) **GROWTH:** Delayed growth, below 5th percentile, delayed development

( ) **HEART:** Murmurs, blood pressure issues, other defects: _____

( ) **LUNGS:** Asthma, RSV, Wheezing, Shortness of breath with exercise

( ) **EATING:** Poor appetite, difficulty swallowing, episodes of vomiting, spitting up, constipation

( ) **SKIN:** Rashes, Eczema

( ) **BLOOD:** Prolonged bleeding, nose bleeds, excessive bruising

( ) **HEARING:** Decreased hearing, recurrent ear infections

( ) **NERVOUS SYSTEM:** Seizures, ADD/ADHD, Decreased tone, Spasticity, Spina Bifida, Downs Syndrome