CHILDREN'S NATIONAL
UROLOGY DEPARTMENT
NEW PATIENT SELF INFORMATION

(Please complete both sides of this form and give it to the nurse at your visit)

Today's Date:_____

Patient name:_____ **Birthdate:**_____
Name of person filling out form:_____ **Relationship to the patient:**_____
Age:_____ **Male:**_____ or **Female**: _____

What is your child's main problem?_____
_____

Describe the symptoms and for how long _____
_____
_____
_____

Other concerns:_____
_____
_____

PAST MEDICAL HISTORY

Birth History			How much did your baby weigh at birth?		
Was your baby full term?	☐ Yes	☐ No	If not, how many weeks?		
Any problems during pregnancy?	☐ Yes	☐ No	Problems during labor?	☐ Yes	☐ No
Problems during delivery?	☐ Yes	☐ No	Did your child have breathing problems?	☐ Yes	☐ No
Did you and your child go home together?	☐ Yes	☐ No	If you didn't, how long did your child stay in the hospital?		

List Prior Hospitalizations and Surgeries (most recent first) **If more than 3 (please specify number): _____**			
Age	**Problem**	**Hospital Name**	**Dates in Hospital or Surgery**

Blood transfusion: Yes____ No ____ Immunizations up to date? Yes ____ No ____

Any known heart condition: (example: murmur) _____

Medication History:			
Drug name	**How much and how often?**	**When did your child start taking it?**	**For what condition or reason?**
Allergy History:			
What Drugs?			
What Foods?			
What Inhaled or Seasonal?			

Urinary History				
Wetting accidents at night	☐ Yes	☐ No	If yes, how often?	
Wetting accidents in day	☐ Yes	☐ No	If yes, how often?	
Urinary tract infections	☐ Yes	☐ No	If yes, how many?	
Urinating problems	☐ Yes	☐ No	If yes, how often?	
Kidney Problems	☐ Yes	☐ No		

FAMILY HISTORY:

List the names of everyone living with the child? Including parent(s), brother (s), sister(s), etc.	**Relation to Child**	**Age**	**Sex**	**List medical problems (include allergies, migraines, gastrointestinal & other)**

SOCIAL HISTORY:

Name of the child's legal guardian? (If applicable):_____
Exposure to well or spring water?_____ Any travel outside the country?_____
Exposure to tobacco smoke?_____Are there any pets?_____
What grade is your child in?_____
The child's school performance is:_____excellent_____ good_____ fair_____ poor_____

OTHER RELEVANT:

List tests/studies performed: (including blood work, urine/stool studies and x-ray/ultrasound)

General Review of Systems (circle all that apply):			
General	**Heart**	**Ear, Nose Throat**	**Stomach / Intestines**
☐ Fever	☐ Turning Blue or Pale	☐ Ear Pain or Infections	☐ Vomiting/Nausea
☐ Tiredness	☐ Heart Murmur	☐ Runny Nose	☐ Abdominal Pain
☐ Pale	☐ Tires easily during exercise or play	☐ Sinus Problems	☐ Diarrhea
Skin	☐ Palpitations	☐ Hearing Problems	☐ Constipation
☐ Eczema	☐ High blood pressure	**Nerves**	☐ Stool accidents
☐ Rashes	**Lungs**	☐ Headache or Migraines	☐ Poor Appetite or Feeding Problems
☐ Itching	☐ Chest Pain	☐ Seizures	☐ Weight Loss or Poor Weight Gain
Puberty	☐ Wheezing or Coughing	☐ Developmental Delay	**Joints**
☐ Pubic hair	☐ Problems Breathing	☐ Wheel chair bound	☐ Joint Pain
☐ Menses	☐ Chocking or Gagging	☐ Learning difficulty	☐ Joint Stiffness
Hormone / Endocrine	☐ History of Asthma	☐ V-P Shunt	☐ Scoliosis
☐ Thyroid	**Eye**	☐ Autism	
☐ Diabetes	☐ Vision Problems	☐ ADHD (Attention Deficit Disorder)	
☐ High Cholesterol	☐ Eye Pain		