IU Health Physicians

Riley Pediatric Urology

CHILD HISTORY FORM

Last Name _____ First Name _____ M.I. _____

Referring Doctor _____ Date of Birth _____

Chief Complaint (Reason for Visit Today) _____

Duration of Problem _____ Signs / Symptoms _____

List anything that improves or worsens the problem _____

Severity (Circle One): Not Severe 1 2 3 4 5 6 7 8 9 10 Very Severe

Doctor's Notes _____

MEDICATIONS
(CURRENTLY TAKING)

Name	Amount	Times / Day

CHILD'S MEDICAL HISTORY

Cerebral Palsy	Y	N	Asthma	Y	N
Prenatal Hydronephrosis	Y	N	Urinary Tract Infections	Y	N
Heart Murmur	Y	N	Constipation	Y	N
Developmental Delay	Y	N	Hypertension	Y	N
Seizure Disorder	Y	N	Spina Bifida	Y	N
Bleeding Disorder	Y	N	VP Shunt	Y	N
Hepatitis	Y	N	Other		
Cancer	Y	N	_____		
TYPE _____			_____		

LIST ANY ALLERGIES

☐ No Allergies Are You Allergic to Latex? Y N

Medication Allergies ☐ None

LIST ANY PAST SURGERIES / HOSPITALIZATION

Type	Year

FAMILY HISTORY

			FAMILY MEMBER
Vesicoureteral Reflux	Y	N	
Kidney Disease	Y	N	
Nighttime Wetting	Y	N	
Urinary Tract Infection	Y	N	
Kidney Failure	Y	N	
Diabetes	Y	N	
Kidney Stones	Y	N	
Anesthesia Problems	Y	N	
Cancer	Y	N	

SOCIAL HISTORY

History of Abuse Y N

Special Diet Y N

Describe _____

Special Needs (wheelchair, braces, etc.) Y N

List _____

Age of Toilet Training _____

With whom does the child live?

_____

_____

_____

PLEASE COMPLETE BOTH SIDES OF THIS FORM

Review of Systems

Does your child now, or has your child had any problems related to the following systems? Circle Yes or No.

CONSTITUTIONAL

Fever	Y / N
Chills	Y / N
Headache	Y / N
Abnormal Development	Y / N

EYES

Blurry Vision	Y / N
Redness	Y / N
Redness	Y / N

Date of Most Recent Eye Exam: _____

Name of Eye Doctor: _____

ALLERGIC/IMMUNOLOGIC

Hay Fever	Y / N
Drug Allergies	Y / N
Food Allergies	Y / N

NEUROLOGIC

Tremor	Y / N
Coordination Problems	Y / N
Abnormal Walk	Y / N
Confusion	Y / N
Numbness	Y / N
Tingling	Y / N

EARS, NOSE, THROAT

Ear Infection	Y / N
Sore Throat	Y / N
Sinus Problems	Y / N

GASTROINTESTINAL

Abdominal Pain	Y / N
Nausea / Vomiting	Y / N
Stool Incontinence	Y / N
Constipation	Y / N
Blood In Stool	Y / N

CARDIOVASCULAR

Heart Murmur	Y / N
High Blood Pressure	Y / N
Chest Pain	Y / N

INTEGUMENTARY

Skin Rash	Y / N
Persistent Itching	Y / N
Easy Bruising	Y / N

MUSCULOSKELETAL

Joint Pain	Y / N
Neck Pain	Y / N
Back Pain	Y / N
Muscle Pain	Y / N

RESPIRATORY

Wheezing	Y / N
Frequent Cough	Y / N
Shortness of Breath	Y / N

ENDOCRINE

Excessive Thirst	Y / N
Too Hot / Cold	Y / N
Tired / Sluggish	Y / N
Abnormal Hair Growth	Y / N

GENITOURINARY

Painful Urination	Y / N
Bloody Urine/Underwear	Y / N
Urinary Retention	Y / N
Frequent Urination	Y / N
Urgency to Urinate	Y / N
Daytime Wetting	Y / N
Nighttime Wetting	Y / N

HEMATOLOGIC/LYMPHATIC

Swollen Lymph Glands	Y / N
Blood Clotting Issues	Y / N

PSYCHIATRIC

Anxiety	Y / N
Depression	Y / N

HAS YOUR CHILD HAD ANY X-RAYS?

Type of X-Ray	Date	Hospital

Does Your Child Have Any Siblings?

Names	Age

Does your child have any other Medical Problem about which we should know? (Please List Below)

_____

_____

_____

Physician _____ **Date** _____