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Urology New Patient (Pediatrics)

Patient Name: _____ Date of Birth: _____ Today's Date: _____
First Middle Initial Last

Reason for your visit today? Be precise.

Physician that referred you for care at John Muir Urology:

Pediatrician: _____

PEDIATRIC HISTORY

Height: _____	Date: ____ / ____ / ____ <small>Month Day Year</small>
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Weight: _____	Date: ____ / ____ / ____ <small>Month Day Year</small>
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PRENATAL

Pregnancy:

Complications? **YES** **NO** If YES, please explain:

Delivery:

Gestational Age:

Vaginal C Section (please explain reason):

CHILD'S PAST MEDICAL HISTORY	YES	NO	COMMENTS
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	
Developmental Concerns	<input type="checkbox"/>	<input type="checkbox"/>	
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	
Lung Problems	<input type="checkbox"/>	<input type="checkbox"/>	

CHILD'S PAST SURGICAL HISTORY	YES	NO	Procedure/Date
Circumcision	<input type="checkbox"/>	<input type="checkbox"/>	
Tonsils	<input type="checkbox"/>	<input type="checkbox"/>	
Testicle Surgery	<input type="checkbox"/>	<input type="checkbox"/>	
Kidney Surgery	<input type="checkbox"/>	<input type="checkbox"/>	
Hernia	<input type="checkbox"/>	<input type="checkbox"/>	
Appendix	<input type="checkbox"/>	<input type="checkbox"/>	
Bladder Surgery	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Surgery	<input type="checkbox"/>	<input type="checkbox"/>	

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FAMILY HISTORY

RELATION	AGE(S)	STATE OF HEALTH	IF DECEASED, CAUSE/AGE OF DEATH
Mother			
Father			
Siblings			

Are you of Ashkenazi Jewish **YES** **NO**

Please list any diseases that run in your family, such as cancer, kidney stones, diabetes, etc.

Disease	Family member

REVIEW OF SYSTEMS

Has your child experienced any of these problems

	YES	NO		YES	NO
Constitutional Symptoms:			Hematologic:		
Fevers			Easy bruising		
Chills			Bleeding Disorder		
Headaches			Allergic:		
Eyes			Allergies		
Poor vision			Hay Fever		
Head and neck:			Neurologic:		
Hearing loss			Seizures		
Sore throat			Muscle Weakness		
Cardio Vascular:			Genital:		
High Blood Pressure			Hernia		
Heart Murmur			Testicle Problems		

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Respiratory:			Hypospadias		
Cough			Developmental:		
Asthma			ADHD		
Gastrointestinal:			Depression		
Constipation			Anxiety		
Diarrhea			Age Potty Trained:		
			Age Menses Began:		
Broken Bone					

SOCIAL HISTORY

GRADE IN SCHOOL:	
SCHOOL ATTENDING:	
LIVING WITH:	<input type="checkbox"/> MOM <input type="checkbox"/> DAD <input type="checkbox"/> BOTH <input type="checkbox"/> OTHER:
LEGAL GUARDIAN:	<input type="checkbox"/> MOM <input type="checkbox"/> DAD <input type="checkbox"/> BOTH <input type="checkbox"/> OTHER:
	If other does that person have legal documents allowing for medical treatment? <input type="checkbox"/> YES <input type="checkbox"/> NO
CIGARETTE USE:	<input type="checkbox"/> YES <input type="checkbox"/> NO
ALCOHOL USE:	<input type="checkbox"/> YES <input type="checkbox"/> NO

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CURRENT MEDICATION			
DRUG NAME	DOSE	FREQUENCY	PRESCRIBING PHYSICIAN

ALLERGIES	
<input type="checkbox"/> No Known Allergies <input type="checkbox"/> Penicillin <input type="checkbox"/> Codeine <input type="checkbox"/> Sulfa <input type="checkbox"/> Cipro <input type="checkbox"/> Macrobid	
MEDICATION	SPECIFIC TYPE OF REACTION

CONSENT TO ACCESS MEDICATION HISTORY	
<p>In order to provide you with the best possible care, your prescriptions will be written electronically whenever possible. Electronic prescribing is now a common practice due to healthcare initiatives requiring the use of electronic medical records. With your permission, e-prescribing will provide us access your medication history electronically, enabling us to see critically important information on your current and past prescriptions, better assess potential medication issues, and improve safety and quality of care.</p> <p>By signing below I give my consent to John Muir Health to access my medication history electronically and to the best of my knowledge, I verify that the above medical information is complete and correct. I understand that it is my responsibility to inform my physician if I ever have a change in my health.</p>	
*** SIGNATURE: Patient or Legally Authorized Individual	Date
Print Name	If Signed on Behalf of Patient, Relationship to Patient

PREFERRED OUTSIDE PHARMACY
<p>Name & Address (Location) of Preferred <u>OUTSIDE</u> Pharmacy: Is this is a MAIL ORDER PHARMACY?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Please list a local pharmacy for urgent prescriptions if primary is a mail order. Name & Address of LOCAL pharmacy:</p>