Academic Urology Practice

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Pediatric Urology

Patient Information Form

Patient Name: ______________________________ Date of Birth: _________

Reason for visit: ____

____

Medications: _________________ _________________

_________________ _________________

Allergies: [] None ______________________________________

Prior Medical Problems: ____

____

Prior Surgery: ____

Pediatrician: ____

address ____

Phone # ____

Referring Physician: ____

address ____

phone # ____

Pediatric Review of Systems

General:

- fever
- fatigue
- appetite or weight changes
- irritability

Ear, Nose Throat, Mouth:

- ear discharge/pain
- congestion, rhinorrhea, sneezing
- sore throat
- mouth sores

Cardiovascular:

- Cyanosis
- chest pain
- palpatations

Respiratory:

- apnea
- choking
- coughing
- wheezing

Genitourinary:

- dysuria
- difficulty urinating
- urgency
- frequency
- enuresis
- flank pain
- blood in urine

Boys

- penile discharge/pain/swelling
- scrotal swelling
- testicular pain

Girls

- vaginal bleeding, pain or discharge

Gastrointestinal:

nausea and vomiting
abdominal distention or pain
diarrhea
constipation
blood in stool

Musculoskeletal:
back pain
gait problems
joint swelling
myalgias

Neurological:
headaches
seizures
speech difficulty
weakness

Psych:
ADD/ADHA,
Autism spectrum
behavior problems
depression
nervous/anxious
sleep disturbances

Please save this form to your computer and then email it as an attachment to Dr. Freedman's office.