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pediatrix
UROLOGY OF CENTRAL TEXAS

Past Medical History

Patient Name: * _____

Date of Birth: * _____

Medications

Current medications: * _____

Allergies

List all known allergies (medications, foods, or environmental): * _____

Previous Hospitalization(s): *Symptom & Date*

*_____

Previous Surgeries: *Procedure & Date*

*_____

Has your child had any blood transfusions? **No** ____ **Yes** ____

Has your child been circumcised? **No** ____ **Yes** ____ When? _____

Medical Conditions/Problems

*Please list any other known medical issues:

_____

Reason for today's visit: * _____

Has your child had any lab test or x-rays for this problem? **No** ___ **Yes** ___

If YES which test, when and where were they performed? _____

_____

Pharmacy Name: * _____ Pharmacy Address: * _____

Questions for Prenatal Only

When is your Due Date? _____ Who will be the Baby's PCP? _____

Who is your Obstetrician? _____ Which Hospital will you deliver?_____

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Past Medical History

Social History

Parent 1 occupation: * _____

Parent 2 occupation: _____

Please list names and ages of siblings:

_____

_____

_____

Who lives in the Household? _____

Child's daytime activities

Home	**No** ____	**Yes** ___
Daycare	**No** ____	**Yes** ___
Recreation/Sports	**No** ____	**Yes** ___

List sports: _____

Birth History

Illness during the pregnancy of this child:

No ___ **Yes** ___ Explain: _____

Medications taken during pregnancy:

No ___ **Yes** ___ Explain: _____

Delivery: **Full Term** ____

Pre-Term ____ # of weeks _____

Late: _____

Problems during delivery:

No ___ **Yes** ___ Explain: _____

_____

Family history

Please list any family members (parent, sibling, grandparent, or other relatives) who have had any of the following medical conditions:

Bleeding Disorder	No ____	Yes ____	If yes, relation: _____
Anesthesia Complication	No ____	Yes ____	If yes, relation: _____
Kidney Failure	No ____	Yes ____	If yes, relation: _____
Kidney Stones	No ____	Yes ____	If yes, relation: _____
UTI	No ____	Yes ____	If yes, relation: _____
Hydronephrosis "extra urine in kidney"	No ____	Yes ____	If yes, relation: _____
Hypospadias "urine opening too low"	No ____	Yes ____	If yes, relation: _____
Diabetes	No ____	Yes ____	If yes, relation: _____
Hypertension	No ____	Yes ____	If yes, relation: _____
Vesicoureteral Reflux	No ____	Yes ____	If yes, relation: _____
Other	No ____	Yes ____	If yes, relation: _____

Patient Past Medical History

Ear/Eye Problems	No ___	Yes ___	
Seizures	No ___	Yes ___	
Heart Problems/Murmurs	No ___	Yes ___	
Pneumonia	No ___	Yes ___	
Diarrhea/Constipation	No ___	Yes ___	
Frequent Nosebleeds/Bruising	No ___	Yes ___	
Anesthesia Problems	No ___	Yes ___	
Diabetes	No ___	Yes ___	
Developmental Problems	No ___	Yes ___	
Psychiatric Problems	No ___	Yes ___	
Nose/Sinus/Throat Problems	No ___	Yes ___	
Headaches/Dizziness	No ___	Yes ___	
Asthma/Bronchitis	No ___	Yes ___	
Stomach Problems	No ___	Yes ___	
Bleeding/Clotting Problems	No ___	Yes ___	
Sickle Cell disease Trait G6PD	No ___	Yes ___	
Cancers	No ___	Yes ___	
Behavioral/Emotional Problems	No ___	Yes ___	
School Problems	No ___	Yes ___	
Muscle/Bone Problems	No ___	Yes ___	

Name of Patient: * _____

Signature of Patient (or responsible party if a minor): * _____

Date: * _____