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UROLOGY OF CENTRAL TEXAS

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Patient's Name: ________________________________ **DOB:** ____________

CHECK any symptoms

Must be completed on the day of your Telemedicine Visit

CONSTITUTIONAL: Weight loss ___ Fever ___ Chills ___ Weakness ___ Tiredness ___ **No symptoms** ___

Head and Eyes: Visual loss ___ Blurred vision ___ Double vision ___ Yellow eyes ___ Headaches ___ Concussions ___ **No symptoms** ___

Ears, Nose, Throat: Hearing Loss ___ Ear Infections ___ Tonsillitis ___ Trouble breathing ___ Bloody Nose ___ Sneezing ___ Congestion ___ Runny Nose ___ Sore Throat ___ **No symptoms** ___

SKIN: Rash ___ Itching ___ Skin issues ___ **No symptoms** ___

CARDIOVASCULAR: Chest pain ___ Palpitations ___ Swelling ___ Cyanosis (child turns blue) ___ Heart murmurs ___ **No symptoms** ___

RESPIRATORY: Shortness of breath ___ Cough ___ Productive cough ___ Pneumonia ___ Bronchiolitis ___ Wheezing ___ Chronic cough ___ Recent RSV ___ Coughing up blood ___ TB ___ Asthma ___ **No symptoms** ___

GASTROINTESTINAL: Nausea ___ Vomiting ___ Diarrhea ___ Abdominal pain ___ Blood in stool ___ Change in stool color ___ Constipation ___ Jaundice (yellow color to skin) ___ Colic ___ Loss of appetite ___ **No symptoms** ___

NEUROLOGICAL: Headaches ___ Dizziness ___ Fainting ___ Paralysis ___ Numbness ___ Tingling in hands or feet ___ **No symptoms** ___

MUSCULOSKELETAL: Muscle pain ___ Back pain ___ Joint pain ___ Joint stiffness ___ Joint swelling ___ Scoliosis ___ Muscle weakness ___ Recent injuries ___ Changes in walking ___ **No symptoms** ___

HEMATOLOGIC: Anemia ___ Abnormal bleeding/bruising ___ Sickle cell disease/trait ___ G6PD disease ___ History of cancer ___ **No symptoms** ___

LYMPHATICS: Enlarged lymph nodes ___ **No symptoms** ___

PSYCHIATRIC: History of depression/anxiety ___ ADHD ___ Behavioral/emotional issues ___
Autism Spectrum Disorders (ASD) ___ **No symptoms** ___

ENDOCRINOLOGIC: Abnormal sweating ___ Cold or heat intolerance ___ Abnormal thirst ___
No symptoms ___

ALLERGIES: Seasonal allergies ___ Asthma ___ Hives ___ Eczema ___ Runny nose ___
Allergies to food ___ **No symptoms** ___

UROLOGIC REVIEW OF SYSTEMS

VOIDING: Burning when urinating ___ Urgency with urinating ___ Frequency with urinating ___
Holding urine for long periods of time ___ Daytime wetting accidents ___
Bed wetting ___ Dribbling of urine ___ UTIs ___ Blood in the urine ___
Difficulty toilet training ___ Weak urine stream ___ Deflected urinary stream ___
Difficulty initiating urine stream ___ Flank pain (pain in the side and back) ___

Males:

Genitourinary: Scrotal pain ___ Testicular pain ___ Penile pain ___ Foreskin problems ___

Females:

MENSTRUAL HISTORY

Age at start of menses __________

Number of days in menstrual cycle ________

Date of start of last menstrual period _____________

Parent/Guardian Name (Printed): ______________________________

Parent/Guardian Signature: ______________________________

Relationship to Patient: ______________________ **Date:** ______________