Pediatric Urology
of Western New York

PEDIATRIC MEDICAL INFORMATION

Patient Name: **Date of Birth:**

Primary care physician: Referring physician

Reason for Consultation: _____

BIRTH HISTORY

__ Unknown

__ Full Term __ Preterm (less than 40 weeks) # of weeks at delivery _____

__ Vaginal or Cesarean Section (circle one)

NICU Stay? Circle one: Yes or No Duration of NICU stay: _____ Reason for stay: _____

CHRONIC MEDICAL PROBLEMS: (Please check all that apply) ___ NONE

___ Heart Murmur
___ Asthma/Reactive airway disease
___ Gastroesophageal reflux
___ Febrile seizure
___ Urinary tract infection
___ Recurrent urinary tract infection
___ ADHD
___ Allergies
___ Birth defect
___ Bleeding problems
___ Cancer
___ Cerebral palsy
___ Depression
___ Down syndrome
___ Epilepsy/Seizures
___ Sickle cell anemia
___ Other: (Please list below)
_____
_____
_____
_____

SURGERIES AND HOSPITALIZATIONS (WITH AGE OR DATE) - Please list below: __ NONE

_____
_____
_____
_____

If your child had surgery, did they have any problems with anesthesia? Yes No
If yes, please explain:

_____

CURRENT MEDICATIONS - Please list on attached form. __ NO MEDICATIONS

ALLERGIES - Please list below: __ NO KNOWN ALLERGIES

____ Medications: _____
____ Food: _____
____ Latex

SOCIAL HISTORY - Who does the child live with? Please check all that apply:

__ Mom __ Dad __Step-mom __Step-dad __Sister(s) __Brother(s) __Other: _____

How many siblings does the child live with? _____

Are there any pets in the house? Yes No

Does anyone who cares for the child smoke? Yes No

FAMILY HISTORY - Does anyone in your FAMILY have any of the following? Please check all that apply:

__ Reactions to anesthesia
__ Bleeding problems
__ Renal/Kidney Failure
__ Kidney Transplant
__ Hypertension
__ Kidney Stones
__ Bedwetting
__ Recurrent UTIs
__ Hypospadias
__ Vesicoureteral reflux
__ Other: (Please list below)
_____

MEDICATION LIST

Patient Name: **Date of Birth:**

Please list all the medications, herbs, or vitamins that your child is taking. If you do not know all the information, please call your pharmacy. This information is essential for your child's visit today.

*If the child is not taking any medication, please check the box below:

___ **NO MEDICATION** for this patient.

	Medication	Strength	Dosage
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			

If you need more space, please use the back of this sheet.

Pharmacy Name: _____ Pharmacy Phone: _____
Pharmacy Address: _____

SureScripts Consent

I, _____, give consent to Pediatric Urology of Western New York to retrieve and use my child's medication history from SureScripts.

Relationship to Patient: _____ Parent/Guardian: _____

SIGNATURE WILL ALSO BE OBTAINED ELECTRONICALLY.

Parent/Guardian Name (printed): _____

Patient Address: _____

Best Phone number to call/text: _____ Phone Carrier: _____

Parent email address: _____

Patient: Date of Birth: Date:

REVIEW OF SYSTEMS

Please check all symptoms which have been ongoing during the last 6 months:

GENITOURINARY
__ Pain with urination
__ Difficulty urinating
__ Daytime urinary accidents
__ Urinary frequency
__ Urinary urgency
__ Foul smelling urine
__ Recurrent urinary tract Infections
__ Blood in urine
__ Vaginal redness/itching
__ Bedwetting
__ Stomach aches
__ Back pain

__ Evaluation of the foreskin
__ Foreskin infections
__ Penile adhesions
__ Deviated urinary stream
__ Small urinary opening
__ Labial adhesions

__ Undescended testicle
__ Right __ Left
__ Scrotal swelling
__ Right __ Left
Scrotal pain
__ Right __ Left
__Hypospadias

GASTROINTESTINAL
Stool frequency & consistency:
(Please check all that apply)
__ Hard balls __ Daily
__ Firm __ Every 2-3 days
__ Soft __ Couple times
__ Loose per week
__ Pain with bowel movements
__Stools in underwear
__ GI Reflux/Heartburn

SURGERY
____ NONE
Type:_____
Date:_____
Location:_____

HEART
__ NONE
__ Murmur
__ Currently
__ In the past

HEME
__ NONE :
__ Bleeding problems
__ Sickle Cell Anemia
__ Von Willebrands
__ Iron deficient anemia
__ Anxiety
__ Bruising

LUNGS
__ NONE
__ Asthma
__ Cough
__ Difficulty breathing
__ Croup/Bronchiolitis
__ Pneumonia
__ Wheezing

ENDOCRINE
__ NONE
__ Diabetes
__ Insulin dependent
__ Non-insulin dependent
__ Thyroid disorder
__ High
__ Low

EYES
__ NONE
__ Vision changes/blurriness

NEUROLOGICAL
__ NONE
__ Developmental delays
__ Headaches
__ Seizures
__ Behavioral problems
__ ADD
__ADHD
__ Bipolar
__ Depression
__ Social problems
__ Autism
__ Head/brain injury
__Post-traumatic stress

SLEEP
__ NONE
__ Sound sleeper
__ Snoring
__ Frequent night awakenings

SKIN
__ NONE
__ Dry skin
__ Eczema
__ Flushing
__ Rashes

MUSCULOSKELETAL
__ NONE
__ Joint pain/swelling
__ Muscle weakness

ALLERGIES
__ NONE
__ Foods
__ Medications
__ Latex
__ Other:_____

HOSPITALIZATIONS
____ NONE
Type:_____
Date:_____
Location:_____

I verify that I have reviewed this document and its contents and no other additions are necessary.

Parent/Guardian Signature_____ Date _____

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New Patient Information

Patient Name: Date of Birth:

SSN# (last 4 digits): _____ Gender: ___ Female ____ Male ____Non-Binary Preferred Pronoun: _____

Primary language: _____

Patient's Full Address: _____

_____

Please list all Parent(s)/Legal Guardian(s) who are authorized to consent for health care for the patient:
****If Legal Guardian(s), we MUST have a copy of the court papers appointing guardianship.**

1. Name: _____ Relationship to Patient: _____

   Address: _____ SSN# (last 4 digits): _____

   Mobile Phone Number: _____ Home Phone Number: _____

   Preferred number: (Please circle one) Mobile Home

   Occupation/Employer: _____ DOB: _____

   E-mail Address:_____

2. Name: _____ Relationship to Patient: _____

   Address: _____ SSN# (last 4 digits): _____

   Mobile Phone Number: _____ Home Phone Number: _____

   Preferred number: (Please circle one) Mobile Home

   Occupation/Employer: _____ DOB: _____

   E-mail Address:_____

Is there a court order addressing health care for the patient? ____ Yes ____ No

****If yes, we MUST have a copy of the most recent court order/custody papers on file.**

INSURANCE & BILLING INFORMATION
Person Financially Responsible: Father ___ Mother ___ Other (Relationship)_____

Primary Insurance:
Subscriber's Name: _____

Insurance ID: _____

Group #/Name of Employer: _____

Effective Date: _____

Address: _____

Secondary Insurance
Subscriber's Name: _____

Insurance ID: _____

Group #/ Name of Employer: _____

Effective Date: _____

Address: _____