Patient Name: _____ Date of Birth: _____ Date Completed: _____

Check All Symptoms

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
__ Soft days
__ Loose __ A couple Times/week
__ Pain with bowel movements
__ Stools in underwear
__ GI Reflux/Heartburn

SOCIAL HISTORY
Patient live with:
__ Mom __ Sister
__ Dad __ Brother
__ Other _____

HEART
__ **NONE**
__ Murmur
__ Currently
__ In the past

HEME
__ **NONE**
__ Bleeding problems
__ Sickle Cell Anemia
__ Von Willebrands
__ Iron deficient anemia
__ 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

If the patient is 13+ year old please answer the following:
Has the patient ever smoked?
__ Yes, currently
__ Yes, in the past
__ No

NEUROLOGICAL
__ **NONE**
__ Developmental delays
__ Headaches
__ Seizures
__ Behavior Problems
__ ADD
__ ADHD
__ Bipolar
__ Depression
__ Social Problems
__ Autism
__ Anxiety
__ 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

ALLERGY
__ **NONE KNOWN**
__ Foods
__ Latex
__ Medications: _____
__ Other (list): _____

PHARMACY
Name:_____
Phone: _____
Address:_____
PEDIATRICIAN
Name: _____
Phone: _____

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

Parent Signature: _____ Reviewed by: _____ Date: _____