Advocate Children's Medical Group – Des Plaines
Pediatric Urology

Please complete this form to the best of your ability. If you are unable to fill out this form, please let us know so we can assist you.

Today's Date: _____

Patient's name: _____
Last First M.I.

Date of Birth: _____

Preferred language: _____

Primary Care Provider: _____ Phone: _____

Referred by: ☐Primary Care Provider ☐Other_____

Other Specialists [please list name and specialty] ☐None

_____

_____

Preferred Pharmacy: _____

Reason for Visit

_____

_____

Past Medical History

Medical Conditions [current or past] ☐None

Has your child ever had problems with the following? Please circle Yes or No.

ADD/ADHD	Yes	No		Developmental delay	Yes	No
Anesthesia Related Problems	Yes	No	N/A	Heart Disease	Yes	No
Asthma	Yes	No		Kidney Stones	Yes	No
Autism/Autism Spectrum	Yes	No		Neurological Disorders	Yes	No
Bleeding Problems	Yes	No		Spina Bifida	Yes	No
Clotting Disorders	Yes	No		Urinary Tract Infections	Yes	No

Other Medical Conditions/Illnesses ☐None

_____

_____

_____

To be filled out by provider: Initial _____ Date_____

Hospitalizations [please list name of hospital, length of stay, and reason] ☐None

_____

_____

_____

Previous Labs or Imaging Studies [please list name of test and where it was performed] ☐None

_____

_____

_____

Birth History

Gestational Age: ☐Full term ☐Premature (At _____ weeks gestation) ☐ Post-term

Prenatal Ultrasound: ☐Normal ☐Abnormal (Findings_____)

Postpartum: ☐Normal ☐Prolonged hospital stay ☐NICU

If prolonged/NICU: Hospital Name _____ Length of stay _____

Reason_____

Vitamin K Supplement: ☐Received ☐Declined ☐Unknown/Not Declined

Immunization History

☐Up to Date ☐Declined ☐Other_____

Surgical History [please list procedure(s) and approximate year(s)] ☐None

_____

_____

_____

Medications [please list any herbal or over the counter medicines] ☐None

_____

_____

_____

Allergies [please list any medication, non-medication, or latex allergies] ☐None

_____

_____

Family History

Anesthesia Related Problems	Yes	No	If yes, family member:_____
Bedwetting	Yes	No	If yes, family member:_____
Bleeding Disorders	Yes	No	If yes, family member:_____
Cancer	Yes	No	If yes, family member:_____
Clotting Disorders	Yes	No	If yes, family member:_____
Diabetes	Yes	No	If yes, family member:_____
Dialysis	Yes	No	If yes, family member:_____
Heart Disease	Yes	No	If yes, family member:_____
Hernia or Hydrocele	Yes	No	If yes, family member:_____
Hypertension	Yes	No	If yes, family member:_____
Hypospadias	Yes	No	If yes, family member:_____
Kidney Disease	Yes	No	If yes, family member:_____
Kidney Stones	Yes	No	If yes, family member:_____
Kidney Transplant	Yes	No	If yes, family member:_____
Sickle Cell Disease	Yes	No	If yes, family member:_____
Stroke	Yes	No	If yes, family member:_____
Undescended Testicle(s)	Yes	No	If yes, family member:_____
Urinary Tract Infection (UTI)	Yes	No	If yes, family member:_____
Vesicoureteral Reflux	Yes	No	If yes, family member:_____

Other_____

Social History

Exposure to Secondhand smoke Yes No

School Grade _____

Household members_____

Parent/Guardian's Name _____ Occupation _____

Phone _____

Parent/Guardian's Name _____ Occupation _____

Phone _____

Is there anything else we should know about your child or family?

_____

_____

_____

Review of Systems

Does your child now or has he/she had any recent problems related to the following systems? Circle Yes or No

Constitutional

Fever	Yes	No
Abnormal growth	Yes	No
Acting fussy	Yes	No
Acting tired	Yes	No
Recent weight change	Yes	No
Feeling unwell	Yes	No

Allergies

Food allergy	Yes	No
Drug allergy	Yes	No
Environmental allergy	Yes	No
Allergy to latex	Yes	No

Neurologic

Seizures	Yes	No
Headache	Yes	No

Eyes

Vision problems	Yes	No
Eye pain	Yes	No
Redness	Yes	No

Ear/Nose/Throat

Frequent ear infections	Yes	No
Frequent sore throat	Yes	No
Snoring	Yes	No

Respiratory

Frequent cough	Yes	No
Wheezing	Yes	No

Cardiovascular

Swelling	Yes	No

Gastrointestinal

Hard bowel movements	Yes	No
Infrequent bowel movements	Yes	No
Loose bowel movements	Yes	No
Blood in stool	Yes	No
Soiling	Yes	No
Abdominal pain	Yes	No
Nausea/vomiting	Yes	No

Genitourinary

Weak urinary stream	Yes	No
Straining to urinate	Yes	No
Blood in urine	Yes	No
Painful urination	Yes	No
Frequent urination	Yes	No
Urgency to urinate	Yes	No
Daytime leaking/wetting	Yes	No
Bedwetting	Yes	No

Endocrine

Excessive thirst	Yes	No
Abnormal hair growth	Yes	No

Skin

Dry skin	Yes	No
Rashes	Yes	No

Musculoskeletal

Abnormal gait	Yes	No

Hematologic/Lymphatic

Swollen glands	Yes	No
Bruises easily	Yes	No
Easy bleeding	Yes	No

Psychiatric

Anxiety	Yes	No

Other

_____

_____

_____

Form completed by: _____

☐ MA through interpreter