Virginia Commonwealth University

Medical Center

In the tradition of the Medical College of Virginia

MCV Campus

Department of Surgery
Division of Urology

PEDIATRIC PATIENT HISTORY FORM Today's Date: __________

Child's Name: ____________________________ Date of Birth: __________ Age: ____

Parent's Names: ____
Parent's phone #: (home) ________________ (cell) ______________________

Relationship of person attending visit with child today:
_____ biologic parent _____ foster parent _____legal guardian _____ relative

Pediatrician/Primary Care Doctor: ___________________________
Doctor's Address and Phone number: ______________________________________
____
____

Name, address and phone number of preferred pharmacy: _________________________
____

Reason why your child is here today ____

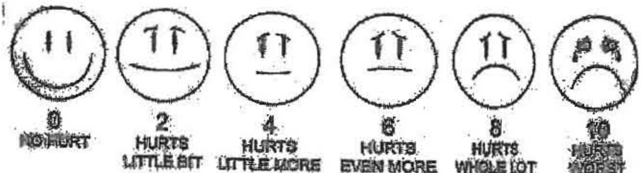
List all current medications, including how much and how often child takes them:
____
____
____

List all allergies (medicine, food, and environmental) and reaction __________________
____

List all previous surgeries:

Date	Reason/type of surgery
________	________________________________
________	________________________________
________	________________________________
________	________________________________

Are child's shots/immunizations up to date? ___ Yes ____ No
Do any household members smoke? ____ Yes ____ No
Does child attend school? ____ Yes ____ No If yes, what grade? _____
Is child having any pain today? ___ Yes ____ No
On a scale of 1 to 10, what is his/her pain level? _____



(more questions on back)

Persons living in home with child:

Name	Age	Relationship	Occupation
______________	______	__________	______________
______________	______	__________	______________
______________	______	__________	______________
______________	______	__________	______________

Medical History (check all that apply to your **child** and/or **family members**, now or in the past)

Child	Family		Child	Family	
_____	_____	high blood pressure	_____	_____	seizures
_____	_____	diabetes	_____	_____	anemia
_____	_____	asthma	_____	_____	bleeding problems
_____	_____	kidney disease	_____	_____	tuberculosis (TB)
_____	_____	recurrent urine infections	_____	_____	heart disease
_____	_____	developmental delay	_____	_____	ADD/ADHD
_____	_____	spinal cord injury	_____	_____	migraines
_____	_____	gastroesophageal reflux	_____	_____	cancer (type)_____
_____	_____	spina bifida	_____	_____	tethered cord

List child's other medical conditions, problems or diagnoses: ______________________________

____

REVIEW OF SYSTEMS

Check any problems your child is having **today**. Please check all that apply

GEN: ____ fever or chills
____ changes in appetite
____ change in weight

ENT: ____ change in vision or blurred vision
____ dry eyes or mouth
____ choking or gagging
____ colds, flu, or sinus infections
____ difficulty hearing
____ recurrent ear infections

CV: ____ chest pain or tightness
____ heart palpitations

RSP: ____ cough/wheeze
____ shortness of breath/difficulty breathing
____ recurrent respiratory infections

GI: ____ nausea or vomiting
____ stomach pain/cramping
____ diarrhea or constipation (circle one)

INT: ____ skin changes, rash, hives, or itching

END: ____ sensitivity to heat or cold
____ excessive thirst

MSK: ____ numbness/tingling in arms or legs
____ muscle/joint weakness
____ difficulty walking or crawling
____ back pain
____ delayed motor skills

HME: ____ abnormal bleeding or bruising
____ blood problems

NRO: ____ dizziness ____ headaches
____ fainting ____ seizures
____ speech delay or difficulty

PSY: ____ changes in mood
____ depression or sadness

GU: ____ changes in urination
____ difficulty urinating
____ leaking of urine in day when awake
____ leaking of urine in night while asleep
____ pain/burning with urination
____ discharge from penis or vagina
____ blood in urine
____ swelling of testicles or scrotum

Please describe any other concerns: ____

____

Parent Signature: ______________________ Reviewed by: ______________________