Comprehensive Urology
www.urologist.org

## PATIENT INFORMATION

| PATIENT NAME: LAST | FIRST | MIDDLE |
|---|---|---|
| | | |

| DATE OF BIRTH: | SEX: ☐ MALE ☐ FEMALE | SOCIAL SECURITY NO. |
|---|---|---|
| | | |

| ADDRESS: | CITY: | STATE: | ZIP: |
|---|---|---|---|
| | | | |

| HOME PHONE NO.: | WORK PHONE NO. | CELL/OTHER PHONE NO.: | EMAIL.: |
|---|---|---|---|
| | | | |

| EMERGENCY CONTACT NAME: | PHONE NO.: |
|---|---|
| | |

## INSURANCE

**MEDICARE:** ☐ YES ☐ NO

| IDENTIFICATION NO.: | EFFECTIVE DATE |
|---|---|
| | |

**BLUE CROSS BLUE SHIELD OF MICHIGAN:** ☐ YES ☐ NO

| IDENTIFICATION NO.: | GROUP: |
|---|---|
| | |

| SUBSCRIBER NAME: | RELATION: |
|---|---|
| | |

**MEDICAID:** ☐ YES ☐ NO

| IDENTIFICATION NO.: | PRIMARY SPONSOR: | PHONE NO.: |
|---|---|---|
| | | |

**OTHER INSURANCE** ☐ YES ☐ NO

| ADDRESS | PHONE |
|---|---|
| | |

| IDENTIFICATION NO.: | SUBSCRIBER: |
|---|---|
| | |

| PRIMARY INSURANCE |
|---|
| |

## FATHER'S INFORMATION

| PATIENT NAME: LAST | FIRST | MIDDLE |
|---|---|---|
| | | |

| DATE OF BIRTH: | SOCIAL SECURITY NO. |
|---|---|
| | |

| ADDRESS: | CITY: | STATE: | ZIP: |
|---|---|---|---|
| | | | |

| HOME PHONE NO.: | WORK PHONE NO. | CELL/OTHER PHONE NO.: |
|---|---|---|
| | | |

| EMPLOYER NAME AND ADDRESS: | OCCUPATION |
|---|---|
| | |

## MOTHER'S INFORMATION

| PATIENT NAME: LAST | FIRST | MIDDLE |
|---|---|---|
| | | |

| DATE OF BIRTH: | SOCIAL SECURITY NO. |
|---|---|
| | |

| ADDRESS: | CITY: | STATE: | ZIP: |
|---|---|---|---|
| | | | |

| HOME PHONE NO.: | WORK PHONE NO. | CELL/OTHER PHONE NO.: |
|---|---|---|
| | | |

| EMPLOYER NAME AND ADDRESS: | OCCUPATION |
|---|---|
| | |

Comprehensive Urology
www.urologist.org

## REFERRING PHYSICIAN

| NAME: | | M.D. / D.O. |
|---|---|---|
| ADDRESS: | | |
| CITY: | STATE: | ZIP: |
| PHONE NO.: | FAX: | |

## FAMILY DOCTOR / PEDIATRICIAN (IF NOT THE SAME AS REFERRING DOCTOR)

| NAME: | | M.D. / D.O. |
|---|---|---|
| ADDRESS: | | |
| CITY: | STATE: | ZIP: |
| PHONE NO.: | FAX: | |

## PHARMACY INFORMATION

| NAME: | | |
|---|---|---|
| ADDRESS: | | |
| CITY: | STATE: | ZIP: |
| PHONE NO.: | FAX: | |

## OTHER PHYSICIANS OR OTHER AUTHORIZED INDIVIDUALS

| NAME: | | M.D. / D.O. |
|---|---|---|
| ADDRESS: | | |
| CITY: | STATE: | ZIP: |
| PHONE NO.: | FAX: | |

| NAME: | | M.D. / D.O. |
|---|---|---|
| ADDRESS: | | |
| CITY: | STATE: | ZIP: |
| PHONE NO.: | FAX: | |

Comprehensive Urology
www.urologist.org

## GENERAL INFORMATION

Child's date of birth: _____

Reason for your visit: _____

_____

Has your child been seen by any other physician for this condition? ☐ YES ☐ NO

_____

If yes, who? _____

## PAST MEDICAL HISTORY

Hospital where your child was born: _____

Birth-weight: _____ Type of Delivery: ☐ VAGINAL ☐ C-SECTION

Has you child ever had problems with the following?

Was your child premature? If yes, # of weeks _____ ☐ YES ☐ NO

Were there any abnormalities on prenatal ultrasound? ☐ YES ☐ NO

If yes, please list: _____

Immunizations up to date? ☐ YES ☐ NO

Major illnesses (please list): _____ ☐ YES ☐ NO

_____

_____

Problem reaching growth/developmental milestones? ☐ YES ☐ NO

Does your child follow a special diet? ☐ YES ☐ NO

Does you child have any bleeding disorders? ☐ YES ☐ NO

Please list any surgical procedures and/or prior hospitalizations and the approximate date:

| Procedure/Reason for Hospitalization | Approximate Date |
|---|---|
| | |
| | |
| | |
| | |

Please list any previous X-rays, ultrasounds, or laboratory tests. Include where they were performed, and the approximate date:

| Test | Date | Test | Date |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**MD/NP Signature:** _____

**Date:** _____

Comprehensive Urology
www.urologist.org

## PAST MEDICAL HISTORY (CONT)

Please list all medications your child currently takes (including non-prescription drugs):

Please list any allergies your child has and the type of reaction (i.e.-hives, wheezing):

## FAMILY HISTORY

Please complete the following family history information:

| Relationship to Patient | Alive & Healthy (Yes/No) | Age | History of Urologic (Kidney, Bladder, Genitalia) Problems (Including Bed-wetting) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

## SOCIAL HISTORY

Patient's school grade (if applicable): _____

Who lives at home with the patient?

☐ MOTHER ☐ FATHER ☐ SIBLINGS ☐ OTHER

Please list any recent social/family stresses that your child has recently experienced:

**MD/NP Signature:** _____

**Date:** _____

Comprehensive Urology
www.urologist.org

# Review of systems

Does your child now or has he/she had past problems with the following?

**General**

| | | |
|---|---|---|
| Fever | ☐ Yes | ☐ No |
| Chills | ☐ Yes | ☐ No |
| Abnormal Growth | ☐ Yes | ☐ No |
| Night Sweats | ☐ Yes | ☐ No |

Other _____

**Neurologic**

| | | |
|---|---|---|
| Depression | ☐ Yes | ☐ No |
| Seizures | ☐ Yes | ☐ No |
| Personality changes | ☐ Yes | ☐ No |
| Psychiatric counseling | ☐ Yes | ☐ No |

Other _____

**Head and Neck**

| | | |
|---|---|---|
| Headaches | ☐ Yes | ☐ No |
| Eye pain | ☐ Yes | ☐ No |
| Blurred vision | ☐ Yes | ☐ No |
| Ringing in ears | ☐ Yes | ☐ No |
| Ear pain | ☐ Yes | ☐ No |
| Chronic cold/sinus infection | ☐ Yes | ☐ No |
| Neck stiffness | | |

Other _____

**Cardiovascular**

| | | |
|---|---|---|
| Irregular heartbeat | ☐ Yes | ☐ No |
| Heart murmur | ☐ Yes | ☐ No |
| Chest pain | ☐ Yes | ☐ No |
| High blood pressure | ☐ Yes | ☐ No |

Other _____

**Respiratory**

| | | |
|---|---|---|
| Asthma | ☐ Yes | ☐ No |
| Respiratory allergies | ☐ Yes | ☐ No |
| Chronic cough | ☐ Yes | ☐ No |
| Coughing up blood | ☐ Yes | ☐ No |
| Wheezing | ☐ Yes | ☐ No |

Other _____

**Musculoskeletal**

| | | |
|---|---|---|
| Muscle/joint pain | ☐ Yes | ☐ No |

Other _____

**Gastrointestinal**

| | | |
|---|---|---|
| Chronic abdominal pain | ☐ Yes | ☐ No |
| Nausea/vomiting | ☐ Yes | ☐ No |
| Appetite loss | ☐ Yes | ☐ No |
| Constipation | ☐ Yes | ☐ No |
| Bleeding from rectum | ☐ Yes | ☐ No |

Other _____

**Urinary Tract**

| | | |
|---|---|---|
| Frequent urination | ☐ Yes | ☐ No |
| Blood in urine | ☐ Yes | ☐ No |
| Day wetting | ☐ Yes | ☐ No |
| Painful urination | ☐ Yes | ☐ No |
| Kidney/bladder infection | ☐ Yes | ☐ No |
| Kidney/bladder stones | ☐ Yes | ☐ No |

Other _____

**Female Genitalia**

| | | |
|---|---|---|
| Vaginal bleeding/discharge | ☐ Yes | ☐ No |
| Vaginitis | ☐ Yes | ☐ No |
| Vaginal/labial trauma | ☐ Yes | ☐ No |

Other _____

**Male Genitalia**

| | | |
|---|---|---|
| Penial pain | ☐ Yes | ☐ No |
| Penile/scrotal swelling | ☐ Yes | ☐ No |
| Bent/twisted penis | ☐ Yes | ☐ No |
| Testicular pain | ☐ Yes | ☐ No |
| Testicular trauma | ☐ Yes | ☐ No |

Other _____

**Blood/Lymphatic**

| | | |
|---|---|---|
| Swollen lymph nodes | ☐ Yes | ☐ No |
| Easy bruising | ☐ Yes | ☐ No |
| Clotting problems | ☐ Yes | ☐ No |

Other

**MD/NP Signature:** _____

**Date:** _____