West Shore Urology, P.L.C.

NEW PATIENTS
PEDIATRICS

Today's Date: ______________

Name: ______________________________ **DOB:** ______________

Sex: ________ **Height:** ________ **Weight:** ________

Preferred Pharmacy: ______________________ **Referring Provider:** ______________________

What is your primary complaint?

____

____

How long have you had this problem?

____

MEDICATIONS Currently taking with dosages:

____

Do you take blood thinners?

____

ALLERGIES Updates/Changes/Reaction:

____

Review of Systems:

Have you experienced any of the following within the last 30 days? (circle Yes / No)

Constitutional

Chills	No / Yes
Fever	No / Yes
Weight Loss	No / Yes

HEENT

Blurred Vision	No / Yes
Double Vision	No / Yes
Hearing Loss	No / Yes
Sore Throat	No / Yes

Respiratory

Chronic Cough	No / Yes
Short of Breath	No / Yes
Known TB Exposure	No / Yes
Wheezing	No / Yes

Cardiovascular

Chest Pain	No / Yes
Heart Murmur	No / Yes
Palpitations	No / Yes

Gastrointestinal

Abdominal Pain	No / Yes
Blood in Stool	No / Yes
Constipation	No / Yes
Diarrhea	No / Yes
Heartburn	No / Yes
Loss of Appetite	No / Yes
Nausea	No / Yes
Vomiting	No / Yes

Genitourinary

Dysuria (Burning)	No / Yes
Daytime Wetting	No / Yes
Dribble/Leaking of Urine	No / Yes
Feeling Incomplete Empty	No / Yes
Foul Smelling Urine	No / Yes
Blood in Urine	No / Yes
Nighttime Bedwetting	No / Yes
Nighttime Urination	No / Yes
Penile Discharge	No / Yes
Scrotal/Testicle Mass	No / Yes
Scrotal/Testicle Pain	No / Yes
Swelling Around Urethra	No / Yes
Urgency of Urination	No / Yes
Urinary Frequency	No / Yes
Urinary Retention	No / Yes
Urine Loss w/ Strain	No / Yes

Hematologic / Lymphatic

Easy Bleeding	No / Yes
Swollen Lymph Nodes	No / Yes
Bruising	No / Yes

Metabolic / Endocrine

Excessive Thirst	No / Yes
Fatigue	No / Yes

Psych

Anxiety	No / Yes
Depression	No / Yes
Insomnia	No / Yes

Musculoskeletal

Arthritis	No / Yes
Back Pain	No / Yes
Joint Pain	No / Yes
Neck Pain	No / Yes

Neurological

Difficulty Walking	No / Yes
Headache	No / Yes
Seizures	No / Yes

Immunologic

Asthma	No / Yes
Food Allergies	No / Yes

Skin (Integumentary)

Contact Allergy	No / Yes
Hives	No / Yes
Itching Skin	No / Yes
Rash	No / Yes

Past Medical:

In addition to what is listed above, please check all, if any, that apply below:

Abdominal Pain	☐	Fracture	☐	MRSA	☐
Asthma	☐	Heart Murmur	☐	Pneumonia	☐
Bleeding Disorders	☐	High Blood Pressure	☐	Prematurity	☐
Chicken Pox	☐	HIV/AIDS	☐	Pyelonephritis	☐
Concussion / CHI	☐	Kidney Disease	☐	Seizures	☐
Congenital Heart Disease	☐	Kidney Stones	☐	Sexually Transmitted Disease	☐
Diabetes	☐	Menstrual Problems	☐	Genetic Disorders	☐
Down's Syndrome	☐	Migraines	☐		

Family History:

		Family Member			Family Member
Bladder Cancer	☐	________	Prostate Cancer	☐	________
Kidney Cancer	☐	________	Kidney Stones	☐	________
Diabetes	☐	________			

Other Family History:

Mother ____________________

Father ____________________

All alive and well ____________________

Social History:

Smokers at home? No / Yes

Surgery:

Surgery		Year
Appendix Removed	☐	______
Circumcision	☐	______
Dental Surgery	☐	______
Fracture Surgery	☐	______

Surgery:

Surgery		Year
Heart Surgery	☐	______
Inguinal Hernia Repair	☐	______
Tonsils/Adenoids	☐	______
Umbilical Hernia Repair	☐	______

Other Medical Problems/Other Surgeries:

____

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____

____

____

I certify that the information on this form is correct to the best of my knowledge.

Patient's Signature: ____________________ Today's Date: ____________