PHOENIX CHILDREN'S *Medical Group*®

Urology Patient Questionnaire

Please check any problems (boxes) listed below which have affected your child.

General	Respiratory	Neurological
☐ Fevers	☐ Shortness of Breath	☐ Seizures
☐ Fatigue	☐ Wheezing	☐ VP Shunt
☐ Weight Loss	☐ Recent Upper Respiratory Infection	☐ Cerebral Palsy
☐ Weight Gain	☐ Chronic LungDisease	☐ Leg Weakness
☐ Problems with Anesthesia	☐ Apnea	☐ Spina Bifida
ENT	☐ Asthma	**Musculoskeletal**
☐ Frequent Ear Infections	**Allergic/Immunologic**	☐ Back Pain
Dermatology	☐ Seasonal Allergies	☐ Muscle Weakness
☐ Rash	☐ Latex and/or other allergies	☐ Muscular Dystrophy
☐ Itching	☐ Hives	**Psychiatric**
Cardiovascular	**Gastrointestinal**	☐ Anxiety
☐ High Blood Pressure	☐ Nausea	☐ Depression
☐ Heart Murmur	☐ Vomiting	☐ ADHD
☐ Chest Pain	☐ Constipation	☐ Autism Spectrum Disorder
☐ Cyanosis	☐ Stool Accidents	☐ Developmental Delay
☐ Congenital Heart Disease	☐ Abdominal Pain	
Endocrine	**Genitourinary**	**Hematology/Lymphatic**
☐ Excessive Thirst	☐ Pain or Burning with Urination	☐ Anemia
☐ Excessive Urination	☐ Blood in Urine	☐ Easy Bleeding
☐ Thyroid Disease	☐ Urinary Frequency	☐ Easy Bruising
☐ Growth Problems	☐ Urinary Urgency	☐ Cancer
☐ Diabetes	☐ Daytime Accidents with Urine	☐ Sickle Cell Disease
Genetics	☐ Leaking of Urine	☐ Hemophilia
☐ Chromosome Abnormalities	☐ Bedwetting	**Gynecology**
☐ Syndromes:__________	☐ Difficulty Urinating	☐ Started Menses at Age _____
	☐ Urinary Tract Infections	☐ Menstrual Problems
	☐ Abnormal Urine Steam	☐ Ovarian Cysts
	☐ Flank Pain	☐ Labial Adhesions
	☐ Kidney Stones	

Other:____

☐ None of the above problems apply

Allergies: ☐ Yes ☐ No, If yes, please list: ______________________________

Medications: ☐ Yes ☐ No, If yes, please list: ______________________________

Lives at home with: ______________________ **Parent/LAR Occupation(s):**______________

School/Grade:____________ **Birth History:** Full Term ☐ Yes ☐ No; If premature how many weeks: __________

Prior Hospitalizations:______________________ **Prior Surgeries:** ______________

Family History:(parents, siblings and grandparents only): Diabetes: ☐ Yes ☐ No ______________

Bleeding Disorders: ☐ Yes ☐ No____________ Heart Disease: ☐ Yes ☐ No____________

Anesthesia Problems: ☐ Yes ☐ No____________ Kidney Problems: ☐ Yes ☐ No____________

______________________________ ______________ __________

Signature of Patient/Legally Authorized Representative (LAR) Relationship to Patient Date

____

Printed Name of Patient/Legally Authorized Representative

______________ ______________ __________ __________

Practitioner Signature Practitioner Printed Name Date Time

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