PATIENT HISTORY FORM

Note: This is a confidential record and will be kept in your doctor's office. Information contained here will not be released to anyone without your authorization to do so.

Today's Date: _____ / _____/ _____

Last Name: _____

First Name: _____

Middle: _____

History of Present Illness

What is the main reason for your visit today?

_____

_____

Location of Problem:

Abdomen Back Bladder

Other: _____

How Long Does the Problem Last?

30 Mins 1 Hour Always There

Other: _____

On a Scale of 1-10 with 10 being the most severe, circle the number that best describes the problem:

1 2 3 4 5 6 7 8 9 10

Is Anything Else Occurring at the Same Time?

YES NO

If YES, please explain:

Vomiting/Diarrhea Fever Blood in Urine

Other: _____

When Did you First Notice the Problem?

7 Days Ago 2 Weeks Ago 1 Month Ago

Other: _____

Is the Problem Constant or Variable?

Always There Sometimes There, Sometimes Not

Other: _____

Does Anything Help or Make the Problem Worse?

_____

Does the Problem Interfere with Your Child's Normal Functions?

YES NO

If YES, Please Explain:

_____

PAST MEDICAL, FAMILY & SOCIAL HISTORY

Past Medical History:

_____

_____

Current Medications:

_____

_____

Does Patient Have Any Medication Allergies? YES

NO

If YES, please explain: _____

Pregnancy History for Mother of Patient:

Term Pregnancy: YES NO

If early, how many weeks: _____

Pregnancy: Normal or Abnormal

If Abnormal, Please Explain:

UTI Gestational Diabetes Preeclampsia/Toxemia

Cervical Insufficiency Other: _____

Prenatal Ultrasounds: Normal or Abnormal

If Abnormal, Please Explain: Hydronephrosis

Polyhydramnios Oligohydramnios Other: _____

List Any of the Patient's Past Surgeries or Procedures and When They Occurred:

Surgery *Date(s)*

_____

_____

_____

How Many Siblings Does the Patient Have? _____

Do Any of Them Have any Health Problems?

YES NO

If YES, what kind? _____

List of all Serious Illnesses in Your Immediate Family
(Example: Diabetes, Kidney Failure, Dialysis, Kidney Transplant, etc.)

_____

_____

SOCIAL HISTORY

Lives with Parents?

YES NO

Patient is Adopted?

YES NO

Patient is in Foster Care?

YES NO

Please Circle:

Married or Divorced

REVIEW OF SYSTEMS

Does the Patient now or has the patient had any recent problems related to the following systems?

GENERAL

Fever Y / N
Chills Y / N
Abnormal Growth Y / N
Abnormal Development Y / N
Other: _____

SKIN

Rashes Y / N
Continued Itching Y / N
Easy Bruising Y / N
Other: _____

EYES

Blurred Vision Y / N
Redness Y / N
Pain Y / N
Other: _____

MUSCLE SYSTEM

Joint Pain Y / N
Back Pain Y / N
Muscle Cramping Y / N
Other: _____

ALLERGIES

Hay Fever Y / N
Drug Allergies Y / N
Foods Y / N
Other: _____

EAR / NOSE / THROAT / MOUTH

Ear Infections Y / N
Sore Throat Y / N
Sinus Problems Y / N
Other: _____

NERVOUS SYSTEM

Seizures Y / N
Abnormal Walking Y / N
Abnormal Coordination Y / N
Other: _____

KIDNEY / BLADDER

Blood in Urine Y / N
Burning with Urination Y / N
Frequent Urination Y / N
Other: _____

HORMONE SYSTEM

Excessive Thirst Y / N
Tired / Sluggish Y / N
Abnormal Hair Growth Y / N
Other: _____

LUNGS

Wheezing Y / N
Frequent Cough Y / N
Shortness of Breath Y / N
Other: _____

STOMACH / INTESTINES

Stomach Pain Y / N
Nausea / Vomiting Y / N
Constipation Y / N
Other: _____

BLOOD / LYMPH GLANDS

Swollen Glands Y / N
Blood Clotting Problems Y / N
Other: _____

HEART

Heart Murmur Y / N
High Blood Pressure Y / N
Other: _____