

Today's date: _____ Medical Record #: _____

Patient name: _____

Date of birth: _____

PCP: _____

John T.B. Houston, MD, FAAP
Pediatric Urology
Pediatric Urological Surgery
American Board Of Urology

Please list all medications your child is taking (include non-prescription drugs)

Please indicate allergies your child has to any medications and the type of reaction:

Family History	Still alive & Healthy			History of urologic problems including bedwetting, unusual reactions to anesthesia, blood clotting problems, etc.
	Yes	Age	No	
Mother				
Father				
Sibling				
Sibling				
Sibling				
Sibling				

Social History

School Grade: _____

Lives with parents? Mother Father Both Other _____

Mother's Name: _____ Occupation _____ Home #- _____

Address: _____ Work #- _____ Cell #- _____

City: _____

State: _____ Zip: _____

Father's Name: _____ Occupation _____ Home #- _____

Address: _____ Work #- _____ Cell #- _____

City: _____

State: _____ Zip: _____

Primary Insurance: _____

Secondary Insurance: _____

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Review of Systems

Does your child now or has he/she had any recent problems related to the following systems? Circle **Yes** or **No**

General

Fever Yes No
Chills Yes No
Abnormal growth Yes No
Abnormal development Yes No

Other _____

Eyes

Blurred vision Yes No
Redness Yes No
Pain Yes No

Other _____

Allergies

Hay Fever Yes No
Drug Allergies Yes No
Foods Yes No

Other _____

Nervous System

Seizures Yes No
Abnormal Walking Yes No
Abnormal coordination Yes No

Other _____

Hormone System

Excessive Thirst Yes No
Tired/Sluggish Yes No
Abnormal hair growth Yes No

Other _____

Stomach /Intestines

Stomach pain Yes No
Nausea/vomiting Yes No
Constipation Yes No

Other _____

Heart

Heart Murmur Yes No
High blood pressure Yes No

Other _____

Skin

Rashes Yes No
Continued itching Yes No
Easy bruising Yes No

Other _____

Muscle system

joint pain Yes No
Back pain Yes No
Muscle cramping Yes No

Other _____

Ear /Nose /Throat /Mouth

Ear Infections Yes No
Sore Throat Yes No
Sinus problems Yes No
Snoring Yes No

Other _____

Genital/Urinary

Blood in urine Yes No
Burning w/ urination Yes No
Frequent urination Yes No
Age of onset menstruation (yr) _____ N/A
Regular Menstrual Periods Yes No

Other _____

Lungs

Wheezing Yes No
Frequent cough Yes No
Shortness of breath Yes No

Other _____

Blood/Lymph --lands

Swollen glands Yes No
Blood clotting problems Yes No

Other _____

Psychiatric

ADD/ADHD Yes No
Depression Yes No
OCD Yes No

Other _____