Pediatric Urology Practice John T.B. Houston, M.D.

Children's Community Physician's Association, Chicago, IL AMBULATORY RECORD

Dear Patient: Please take a few minutes to complete the first three pay you of the best possible care and will be held in confide			ıre	
Today's date:				
Patient name:				
Date of birth:				
Reason for this visit:			_	
Primary Care Physician: Referred By: Drimary Physician Other M.D	Self			
PAST MEDICAL HISTORY Has your child ever had problems with the following Immunizations up to date				
	Yes	No		
Was your child premature? If yes, number of weeks	Yes	No		
Abnormal prenatal ultrasound	Yes	No		
Does your child have problems with any of the following:				
Heart disease	Yes	No		
Asthma	Yes	No		
Nervous system	Yes	No		
Autism/Autism Spectrum	Yes	No		
Coordination difficulties	Yes	No		
Developmental milestones	Yes	No		
Bleeding problems	Yes	No		
AIDS/HIV	Yes	No		
Constipation	Yes	No		
Other Medical Conditions/ Illnesses:	Yes	No		

 Please list any surgical procedures your child has had and the approximate year
 Year

 1
 2

 3
 3

Today's date:	
Patient name:	John T.B. Houston, MD, FAAP
	Pediatric Urology
Date of birth:	Pediatric Urological Surgery
PCP:	American Board Of Urology

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

Preferred Pharmacy:

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

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

Social History

School Grade:			
Lives with parents? Mother Father	□Both □ Other		
Mother's Name:	Occupation:	Home #:	
Address:	Work #:	Cell #:	
City:	Email :		
State: Zip:			
Father's Name:	Occupation:	Home #:	
Address:	Work #:	Cell #:	
City:			
State: Zip:			
Primary Insurance:	Insurance ID Num	ber:	
	Group Number:		

ay's date:					_
ent name:				John T.B. Houston	, MD,
e of birth:				Pediatric Urology Pediatric Urologica	al Surg
). 				American Board O	
iew of Systems					
•	she had any	recent prob	blems related to the following sys	tems? Circle Yes	s or N
<u>General</u>			<u>Skin</u>		
Fever	Yes	No	Rashes	Yes	No
Chills	Yes	No	Continued itching	Yes	No
Abnormal growth	Yes	No	Easy bruising	Yes	No
Abnormal development	Yes	No	Other		
Other					
Eyes			Muscle system		
Blurred vision	Yes	No	joint pain	Yes	No
Redness	Yes	No	Back pain	Yes	No
Pain	Yes	No	Muscle cramping	Yes	No
Other			Other		
Allergies			Ear /Nose /Throat /Mouth		
Hay Fever	Yes	No	Ear Infections	Yes	No
Drug Allergies	Yes	No	Sore Throat	Yes	No
Foods	Yes	No	Sinus problems	Yes	No
Other			Snoring	Yes	No
			Other		
<u>Nervous System</u>			Genital/Urinary		
Seizures	Yes	No	Blood in urine	Yes	No
Abnormal Walking	Yes	No	Burning w/ urination	Yes	No
Abnormal coordination	Yes	No	Frequent urination	Yes	No
Other			Age of onset menstruation (yr))	N/A
			Regular Menstrual Periods	Yes	No
			Other		
Hormone System			Lungs		
Excessive Thirst	Yes	No	Wheezing	Yes	No
Tired/Sluggish	Yes	No	Frequent cough	Yes	No
Abnormal hair growth	Yes	No	Shortness of breath	Yes	No
Other			Other		
Stomach /Intestines			Blood/Lymphlands		
Stomach pain	Yes	No	Swollen glands	Yes	No
Nausea/vomiting	Yes	No	Blood clotting problems	Yes	No
Constipation	Yes	No	Other		
Other					
			<u>Psychiatric</u>		
<u>Heart</u>			ADD/ADHD	Yes	No
Heart Murmur	Yes	No	Depression	Yes	No
High blood pressure	Yes	No	OCD	Yes	No
			Other		