Pediatric Urology Practice
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☐ TNP ☐ LP ☐ NLX ☐ WST

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

AMBULATORY RECORD

Dear Patient:
Please take a few minutes to complete the **first three** pages of this form. This will help assure you of the best possible care and will be held in confidence as part of your medical record.

Today's date: _____

Patient name: _____

Date of birth: _____

Reason for this visit: _____

Primary Care Physician: _____

Referred By: ☐ Primary Physician ☐ Self
☐ Other M.D._____ ☐ Friend
☐ Other_____

PAST MEDICAL HISTORY

Has your child ever had problems with the following (Circle One)

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	

Today's date: _____

Patient name: _____

Date of birth: _____

PCP: _____

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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:

_____

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: _____ Email : _____

State: _____ Zip: _____

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

Address: _____ Work #: _____ Cell #: _____

City: _____

State: _____ Zip: _____

Primary Insurance: _____ Insurance ID Number: _____

Group Number: _____

Today's date: _____

Patient name: _____

Date of birth: _____

PCP: _____

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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 _____