PEDIATRIC UROLOGY HEALTH HISTORY

PROVIDENCE Children's Health

ABOUT YOU

Patient Name: _____ DOB: _____/_____/_____
Last First Middle month day year

Patient's legal name (if different) _____

Gender: ☐ Female ☐ Male

What gender does your child identify with? ☐ Female ☐ Male ☐ Non-binary/other

What matters to you today?

BIRTH HISTORY

Born at: ☐ Full term (38-42 weeks) ☐ Premature (<37 weeks) ☐ Unknown

Complications during pregnancy or delivery: ☐ _____ ☐ NA ☐ Unknown

SOCIAL HISTORY

Who lives with your child? _____

What activities does your child enjoy? _____

MEDICAL HISTORY

Has your child ever had surgery? If yes, please list surgery and date

Date	Surgery Type
_____	_____
_____	_____
_____	_____

Does your child have any past or current medical conditions?

Problem	Followed by	Treatment
_____	_____	_____
_____	_____	_____
_____	_____	_____

Has your child ever been diagnosed with a urinary tract infection? ☐ Yes ☐ No

FAMILY HISTORY

Do any Parents, siblings or grandparents have any of these conditions? Please list family members

M= Mother
F= Father
S= Sister
B= Brother
MGM= Maternal Grandmother
PGM= Paternal Grandmother
MGF= Maternal Grandfather
PGF= Paternal Grandfather

Diabetes		Bladder cancer	
High blood pressure		Kidney cancer	
High cholesterol		Kidney stones	
Autism		Bedwetting	
Mental illness		UTI	

If your child is here today for urinary accidents or other urinary problems, please complete the table below:

URINARY HISTORY

Does your child have of the following issues?

Constipation	☐ Yes	☐ No	Blood in urine	☐ Yes	☐ No
Frequent urination	☐ Yes	☐ No	Belly or side pain	☐ Yes	☐ No
Need to urinate urgently	☐ Yes	☐ No	Leg or back pain	☐ Yes	☐ No
Squatting to hold pee	☐ Yes	☐ No	Poop accidents	☐ Yes	☐ No
Painful urination	☐ Yes	☐ No	Snoring	☐ Yes	☐ No