Pediatric Urology Associates, Ltd

Patient Name:______________________________ Today's Date ___/____/____ Date of Birth_____ / ___ /_______

Why is the patient seeing the doctor today?____

Any allergies? No_______Yes____

If yes, please describe:

Taking any medications? No______ Yes_____

If yes, please list:

____

Patient's Past Medical History:

Birth History: Premature Yes_____No____ Full term Yes _____No______

Asthma or lung problems: Yes_____No____

Bleeding disorder: Yes_____No____

Heart problems: Yes_____No____

Other medical problems: Yes_____No____ If yes, please describe:

Immunizations up to date: Yes_____No____

Prior surgery: Yes____No____

If yes: List the surgery and dates:

____

Family History: (Immediate Family Members)

Diabetes Yes_____No_____

Heart Disease Yes_____No_____

Hypertension Yes_____No_____

Kidney Problems Yes_____No_____

Bleeding Disorder Yes_____No_____

Anesthesia problems Yes_____No_____

Occupation: Father_______________________Mother______________________

Patient/Parent/Guardian Signature____

Information verified by: ____

For Office Use Only

Ht______
Wt______
BP______
PCP_______________