Pediatric Urology of Western New York

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NEW PATIENT INFORMATION

Patient Name: _____ Date of Birth:_____

Gender: ___ Female ____ Male ____Non-Binary Preferred Pronoun: _____

Primary Language: _____

Patient's Full Address:

_____

Please list all Parent(s) / Legal Guardian(s) who are authorized to consent for health care for the patient: **If Legal Guardian(s), we MUST have a copy of the court papers appointing guardianship.

Name: _____DOB: _____
Relationship to Patient: _____
Address: _____
Mobile Phone Number: _____
Home Phone Number: _____
Preferred Number: (Please circle one) Mobile Home
Occupation/Employer: _____
E-mail Address:_____

Name: _____DOB: _____
Relationship to Patient: _____
Address: _____
Mobile Phone Number: _____
Home Phone Number: _____
Preferred Number: (Please circle one) Mobile Home
Occupation/Employer: _____
E-mail Address:_____

Is there a court order addressing health care for the patient? ____ Yes ____ No
**We MUST have a copy of the most recent court order/custody papers on file.

INSURANCE & BILLING INFORMATION

Individual Financially Responsible:

Father ___ Mother ___ Other (Relationship)_____

Primary Insurance Subscriber Name: _____

Insurance ID: _____

Group # / Name of Employer: _____

Effective Date: _____

Address: _____

Secondary Insurance Subscriber Name: _____

Insurance ID: _____

Group #/Name of Employer: _____

Effective Date: _____

Address: _____

PEDIATRIC MEDICAL INFORMATION

Patient Name: _____ Date of Birth: _____

Primary Care Physician:_____

Referring Physician (If Different From Primary Physician):_____

Reason for Consultation:

_____

BIRTH HISTORY

__ Unknown

__ Full Term __ Preterm (Less Than 40 Weeks) # of Weeks at Delivery _____

__ Vaginal or Cesarean Section (Circle One)

NICU Stay? Yes or No Duration of NICU Stay: _____

Reason for Stay: _____

CHRONIC MEDICAL PROBLEMS (Please Check All That Apply):

___ None	___ Heart Murmur	___ Allergies
___ Epilepsy / Seizures	___ Asthma/Reactive Airway Disease	
___ Birth Defect(s): _____		___ Sickle Cell Anemia
___ ADHD	___ Autism	___ Gastroesophageal Reflux
___ Bleeding Problems	___ Cancer	___ Urinary Tract Infections
___ Celiac's	___ Depression	___ Anxiety
___ Trisomy	___ Spina Bifida	___ Obstructive Sleep Apnea

___ Other (Please List Below):

_____

SURGERIES AND HOSPITALIZATIONS (Include Age / Date):
__ None
Please list:

_____

_____

If your child had surgery, did they have any problems with anesthesia? (Circle) Yes No
If yes, please explain:

_____

Current Medications: _____
_____ No Medications
Allergies: _____
_____ No Known Allergies

SOCIAL HISTORY

Who does the child live with? Please check all that apply:
__ Mom __ Dad __Sister(s) __Brother(s) How many siblings does the child live with? __
__Stepmother __Stepfather __ Group Home
__ Foster Parent __ Grandparent(s) Other: _____

FAMILY HISTORY

Does anyone in your FAMILY have any of the following? Please check all that apply:
__ Reactions to Anesthesia (If yes, please include who and what the reaction was):

_____
__ Bleeding Problems (If yes, please include who and type of problem)

_____
__ Hypertension __ Vesicoureteral Reflux __ Renal/Kidney Failure
__ Recurrent UTI's __ Kidney Stones __ Bedwetting
__ Kidney Transplant __ Other: (Please List) _____

REVIEW OF SYSTEMS

Please check all symptoms which have been ongoing during the past 6 months:

GENITOURINARY
__ Pain With Urination
__ Difficulty Urinating
__ Daytime Urinary Accidents
__ Urinary Frequency
__ Urinary Urgency
__ Foul Smelling Urine
__ Recurrent Urinary Tract Infections
__ Blood in Urine

HEART
__ None
__ Murmur
__ Currently
__ In the Past

BLOOD
__ NONE
__ Bleeding problems
__ Sickle Cell Anemia

NEUROLOGICAL
__ None
__ Developmental Delays
__ Headaches
__ Seizures
__ Behavioral Problems
__ ADD
__ ADHD
__ Bipolar
__ Depression

GENITOURINARY CONT.

__ Vaginal Redness/Itching
__ Bedwetting
__ Stomachaches
__ Foreskin Infections
__ Penile Adhesions
__Tight Foreskin
__ Deviated Urinary Stream
__ Small Urinary Opening
__ Labial Adhesions
__ Undescended Testicle
__ Right
__ Left
___ Scrotal Swelling
___ Right
___ Left
___ Scrotal Pain

HEART CONT.

__ Von Willebrands
__ Iron Deficient Anemia
__ Bruising

LUNGS

__ NONE
__ Asthma
__ Difficulty breathing
__ Wheezing
__ Cough
__ Croup/Bronchiolitis
__ Pneumonia

NEUROLOGICAL CONT.

__ Social Problems:
__ Autism
__ Anxiety
__ Post-Traumatic Stress

__ Back Pain

__None
__ Frequent Night Awaken
__ Sound Sleeper
__Snoring

ENDOCRINE

___ Diabetes
___ Insulin Dependent
___ Non-Insulin Dependent
___ Hypospadias
___ Thyroid Disorder

SKIN

___ Dry Skin
___ Eczema
___ Flushing
___ Rashes

GASTROINTESTINAL

Stool Frequency and Consistency
Please check all that apply:
__ Daily
__ Firm
__ Soft
__ Loose
__ Pain with Bowel Movements
__ Stools in Underwear
__ GI Reflux/Heartburn
__ Every 2-3 Days
__ Couple times per week

ALLERGIES

__ None
__ Foods
__ Medications
__ Latex
__ Other:_____