

Urology New Patient (Pediatrics)

Patient Name: _____ Date of Birth: _____ Today's Date: _____
First Middle Initial Last
Reason for your visit today? Be precise.
Physician that referred you for care at John Muir Urology:
Pediatrician:
PEDIATRIC HISTORY
Height:
Date: / /
Month Day Year

Weight:
Date: / /
Month Day Year

PRENATAL
Pregnancy:

Complications? **YES** ☐ **NO** ☐ If YES, please explain:

Delivery:

Gestational Age:

Vaginal ☐ C Section ☐ (please explain reason):

CHILD'S PAST MEDICAL HISTORY
YES NO
COMMENTS

Diabetes

☐
☐

High Blood Pressure

☐
☐

Kidney Disease

☐
☐

Heart Problems

☐
☐

Developmental Concerns

☐
☐

Anemia

☐
☐

Diarrhea

☐
☐

Constipation

☐
☐

Cancer

☐
☐

Lung Problems

☐
☐
CHILD'S PAST SURGICAL HISTORY
YES NO
Procedure/Date

Circumcision

☐
☐

Tonsils

☐
☐

Testicle Surgery

☐
☐

Kidney Surgery

☐
☐

Hernia

☐
☐

Appendix

☐
☐

Bladder Surgery

☐
☐

Heart Surgery

☐
☐

Patient Name: _____ Date of Birth: _____ Today's Date: _____
First Middle Initial Last

FAMILY HISTORY					
RELATION	AGE(S)		STATE OF HEALTH	IF DECEASED, CAUSE/AGE OF DEATH	
Mother					
Father					
Siblings					
Are you of Ashkenazi Jewish	YES ☐ NO ☐				
Please list any diseases that run in your family, such as cancer, kidney stones, diabetes, etc.					
Disease	Family member				
REVIEW OF SYSTEMS					
Has your child experienced any of these problems					
	YES	NO		YES	NO
Constitutional Symptoms:			Hematologic:		
Fevers			Easy bruising		
Chills			Bleeding Disorder		
Headaches			Allergic:		
Eyes			Allergies		
Poor vision			Hay Fever		
Head and neck:			Neurologic:		
Hearing loss			Seizures		
Sore throat			Muscle Weakness		
Cardio Vascular:			Genital:		
High Blood Pressure			Hernia		
Heart Murmur			Testicle Problems		

Patient Name: _____ Date of Birth: _____ Today's Date: _____
First Middle Initial Last

Respiratory:			Hypospadias		
Cough			Developmental:		
Asthma			ADHD		
Gastrointestinal:			Depression		
Constipation			Anxiety		
Diarrhea			Age Potty Trained:		
			Age Menses Began:		
Broken Bone					

SOCIAL HISTORY

GRADE IN SCHOOL:	
SCHOOL ATTENDING:	
LIVING WITH:	☐ MOM ☐ DAD ☐ BOTH ☐ OTHER:
LEGAL GUARDIAN:	☐ MOM ☐ DAD ☐ BOTH ☐ OTHER:
	If other does that person have legal documents allowing for medical treatment? ☐ YES ☐ NO
CIGARETTE USE:	☐ YES ☐ NO
ALCOHOL USE:	☐ YES ☐ NO

Patient Name: _____ Date of Birth: _____ Today's Date: _____
First Middle Initial Last

CURRENT MEDICATION			
DRUG NAME	DOSE	FREQUENCY	PRESCRIBING PHYSICIAN

ALLERGIES	
☐ No Known Allergies ☐ Penicillin ☐ Codeine ☐ Sulfa ☐ Cipro ☐ Macrobid	
MEDICATION	
MEDICATION	SPECIFIC TYPE OF REACTION
CONSENT TO ACCESS MEDICATION HISTORY	
In order to provide you with the best possible care, your prescriptions will be written electronically whenever possible. Electronic prescribing is now a common practice due to healthcare initiatives requiring the use of electronic medical records. With your permission, e-prescribing will provide us access your medication history electronically, enabling us to see critically important information on your current and past prescriptions, better assess potential medication issues, and improve safety and quality of care. By signing below I give my consent to John Muir Health to access my medication history electronically and to the best of my knowledge, I verify that the above medical information is complete and correct. I understand that it is my responsibility to inform my physician if I ever have a change in my health.	
*** SIGNATURE: Patient or Legally Authorized Individual	Date
Print Name	If Signed on Behalf of Patient, Relationship to Patient
PREFERRED OUTSIDE PHARMACY	
Name & Address (Location) of Preferred <u>OUTSIDE</u> Pharmacy: Is this is a MAIL ORDER PHARMACY? ☐ Yes ☐ No	
Please list a local pharmacy for urgent prescriptions if primary is a mail order. Name & Address of LOCAL pharmacy: 	