Pediatric Specialists of Virginia
Division of Urology Ambulatory Treatment Record
Urology Family Questionnaire, Page 1 of 2

PATIENT INFORMATION

Child's First Name: _____ Child's Sex: ☐ Male ☐ Female

Child's Last Name: _____

Child's Birth Date: _____ Child's Age: _____

REASON FOR TODAY'S VISIT

What is the reason for today's visit?

BIRTH HISTORY

Were there any problems during pregnancy? ☐ No ☐ Yes

Was your child full term? ☐ No ☐ Yes

If not full term at how many weeks was child delivered? _____

How much did your child weigh at birth? _____

PRIOR HOSPITALIZATIONS AND SURGERIES

Has your child been hospitalized or had surgery? ☐ No ☐ Yes If yes, list them below, most recent first; if more than 3 specify number: ____

Age	Problem (reason for hospitalization or surgery)	Hospital Name	Hospitalization or Surgery Dates

MEDICATION HISTORY AND RECONCILIATION

Is your child currently taking any prescription, over the counter, or herbal medicines? ☐ No ☐ Yes ☐ Unsure If yes, list them below.

What is the name of the medicine? (one per row)	How much of this medicine is taken per dose?	How many times a day is this medicine taken?	When was the last time this medicine was taken?	What does this medicine treat?

SOCIAL HISTORY

Provide court order if guardian is not natural paren

Are you the child's legal guardian? ☐ No ☐ Yes

If no, list legal guardian's name: Name: _____

What grade is the child currently in? Grade: _____ ☐ Not In School

What is the child's performance in school? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Has the child traveled outside the country? ☐ No ☐ Yes

Is the child exposed to tobacco smoke? ☐ No ☐ Yes

If yes, who smokes?

Please continue answering questions on the back.

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FAMILY HISTORY

Ilnesses present in your child's family members?
Check DK (Don't Know) if you are unsure.

					If any yes's, which family members have which illnesses?
Bleeding Problems	☐ No	☐ Yes	☐ DK	Bleeding Problems	=
Kidney Stones	☐ No	☐ Yes	☐ DK	Kidney Stones	=
Urinary Tract Infections	☐ No	☐ Yes	☐ DK	Urinary Tract Infections	=
Kidney Failure	☐ No	☐ Yes	☐ DK	Kidney Failure	=
Diabetes	☐ No	☐ Yes	☐ DK	Diabetes	=
High Blood Pressure	☐ No	☐ Yes	☐ DK	High Blood Pressure	=
Inguinal Hernias	☐ No	☐ Yes	☐ DK	Inguinal Hernias	=
Undescended Testes	☐ No	☐ Yes	☐ DK	Undescended Testes	=
Abnormalities of Penis	☐ No	☐ Yes	☐ DK	Abnormalities of Penis	=

REVIEW OF SYMPTOMS

Check all symptoms that your child has.

General	No	Yes
Fever	☐	☐
Tiredness	☐	☐

Skin	No	Yes
Eczema	☐	☐
Rashes	☐	☐

Hormone / Endocrine	No	Yes
Diabetes	☐	☐
High Cholesterol	☐	☐

Heart	No	Yes
High Blood Pressure	☐	☐
Heart Murmur	☐	☐

Lungs	No	Yes
Wheezing/Cough	☐	☐
History of Asthma	☐	☐

Eye	No	Yes
Vision Problems	☐	☐

Ear, Nose, Throat	No	Yes
Ear Infections	☐	☐
Sinus Problems	☐	☐

Nerves	No	Yes
Seizures	☐	☐
Developmental Delay	☐	☐
Headache or Migraines	☐	☐
Autism	☐	☐
ADHD Attention Deficit	☐	☐

Joints	No	Yes
Scoliosis	☐	☐
Joint Pain	☐	☐

Stomach / Intestines	No	Yes
Vomiting / Nausea	☐	☐
Abdominal Pain	☐	☐
Feeding Problems	☐	☐
Constipation	☐	☐
Stool Accidents	☐	☐

Thank you for completing this questionnaire.

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