Children Health History Questionnaire Age 0-18 yrs

IDAHO UROLOGIC INSTITUTE

SURGERY CENTER OF IDAHO

Today's Date: _____ Pharmacy: _____

Name: _____DOB: _____

Parents Names: _____

Reason for Visit: _____Primary Care Physician: _____

Have you been seen for this before? (Y / N) _____ All Physicians involved in your care: _____

Do you currently have any pain related to your diagnosis? (Y / N) how would you rate your current pain 0-10? _____

ALLERGIES: Do you have an allergy or have sensitivity to latex or rubber products? (Y / N) □ **No known allergies**

Environmental / Food / Medications:	Reaction:
_____	_____
_____	_____

MEDICATIONS Please include all over the counter medications □ See Medication List □ **No Medications**

_____ _____

_____ _____

SURGICAL HX & HOSPITALIZATIONS: Please list hospital stays due to illness and or surgery: □ See Surgical History List □ **No surgical history**

_____ _____

_____ _____

SOCIAL HISTORY □ Smoke, chew tobacco, or vape □ Drink Alcohol □Recreational /Street Drugs (Y / N)

Packs / cans per day: _____ How much: _____ Type: _____

Age started/quit: _____ How often: _____ Where do you live: Home or Skilled nursing

FAMILY HISTORY: Any history of urologic cancers? (Y / N) Type and Whom: _____

Mother: Age: _____ Pertinent health problems: _____ Cancer (Y / N)Type:_____

Father: Age: _____ Pertinent health problems: _____ Cancer (Y / N)Type:_____

Do you use? □ Glasses □ Contacts □ Hearing Aids □Dentures □ Partials □ Dental Implants □ Cane □Walker □Wheelchair

Do you have any of the following **medical problems**? If yes, please place an "x" in the circle next to the problem.

HEART	LUNG	GASTROINTESTIONAL	GENITOURINARY
o Murmur	o Asthma	o Hernia	o Retention/Catheter
o Irregular heartbeat	o Pneumonia	o Reflux / GERD	o Incontinence
o High blood pressure	o Tuberculosis	o Ulcer	o UTI
o Anemia	o Sleep apnea	o Liver Disease	o Kidney Disease
o bleeding or clotting disorder Type:	o Use CPAP	o Inflammatory Bowel Disease	o Kidney stones
	o Nebulizer		o Reflux/Hydronephrosis
o Blood Clot (PE/DVT)			o Undecended testicles
IMPLANTABLE DEVICES	**NEUROLOGICAL**	**CANCER**	o Hypospadius
o Defibrillator	o Seizures	o Type:	o Foreskin Infection
o Pacemaker	o Developmental Delay		**HEAD & NECK**
o Shunt	o Learning Disability	**ENDOCRINE**	o Nosebleeds
o Vagal Stimulator	o ADD/ADHD	o Thyroid disease	o Tubes in Ears
INFECTIOUS DISEASE	o Spinal Cord Injury level ____	o Diabetes	o Abnormal Drainage
o Exposure to HIV / AIDS	o Muscular Dystrophy	**IMMUNIZATIONS**	
o **C Diff Date:**	o Behavioral Disability	o Up to date	
o **MRSA Date location:**		o Unknown	

Have you or a family member undergone general anesthesia AND had a reaction with the anesthesia ? Malignant Hyperthermia? (Y / N)
If yes please describe: _____

FORM COMPLETED BY Signature: _____Date: _____

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CHILDREN REVIEW OF SYSTEMS

Review of Systems ***Please check any current problems / symptoms within the last 30 days***

General ☐ **NO PROBLEMS**	☐fever ☐lethargy ☐weight loss _____ ☐weight gain _____ ☐weakness	**Genitourinary** ☐ **NO PROBLEMS**	☐painful urination ☐increased frequency ☐urinary urgency ☐blood in urine ☐incontinence accidents _____ ☐urinary tract infections ☐kidney stones
Heart ☐ **NO PROBLEMS**	☐chest pain ☐fainting	**Male reproductive** ☐ **NO PROBLEMS**	☐testicular pain ☐swelling
Lungs ☐ **NO PROBLEMS**	☐cough ☐shortness of breath ☐recent cold ☐wheezing ☐asthma	**Female reproductive** ☐ **NO PROBLEMS**	☐Last menstrual period_____ ☐Currently pregnant Number of pregnancies_____
Gastrointestinal (GI) ☐ **NO PROBLEMS**	☐abdominal pain ☐nausea & vomiting ☐diarrhea ☐constipation	**Nervous / Psychiatric** ☐ **NO PROBLEMS**	☐headaches ☐depression ☐ anxiety
Eyes Ears Nose Mouth ☐ **NO PROBLEMS**	☐vision change ☐dizziness	**Hematologic/Infectious** ☐ **NO PROBLEMS**	☐easy bleeding ☐C Diff Date:_____ ☐MRSA Date:_____
Skin ☐ **NO PROBLEMS**	☐itching ☐rash ☐open wound/poor healing		

Internal Use Only

Surgery Center Reviewed by Sign and Date: _____