Children's Hospital LOS ANGELES
DIVISION OF UROLOGY

INTAKE FORM

Office Visit Date: _____/____/_______ **Child's Date of Birth:** _____/____/_______
Child's First Name: ____________________ **Child's Last Name:** ____________________

You are the child's: ☐ Biological Parent ☐ Foster Parent ☐ Adoptive Parent ☐ Legal Guardian

PRIMARY PHYSICIAN NAME: ____
Address: __________________________________ Phone: ____________
Fax: ____________
Pharmacy Name: ☐ CVS ☐ Rite Aid ☐ Walgreens ☐ Other: ____________________
Address: __________________________________ Phone: ____________
Cross Street: ____________________ City: ____________ Zip Code: ____________

1) **Why was your child referred to our office?**
____
____

2) **Has your child ever been hospitalized?**
Yes No
☐ ☐ Please explain____
____
____

3) **Has your child ever had surgery?**
Yes No
☐ ☐ Please explain ____
____

4) **Does your child have any significant medical problems (please discuss all that apply):**
Yes No
☐ ☐ Born Premature? #weeks: ______ time in the NICU? __________
☐ ☐ Neurologic Problems (seizures, spine problems, etc.) ____________________
☐ ☐ Ears, Nose, Throat (sleep apnea, ear infections, etc.) ____________________
☐ ☐ Heart Problems (murmurs, etc.) ______________________________
☐ ☐ Lung Problems (asthma, etc.) ______________________________
☐ ☐ Gastrointestinal Problems (acid reflux, etc.) ________________________
☐ ☐ Endocrine (diabetes, thyroid, etc.) ____________________________
☐ ☐ Blood/Immune Problems (bleeding, infections, etc.) ____________________
☐ ☐ Musculoskeletal (muscles, bones, etc.) __________________________
☐ ☐ Other: ____

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5) **Does your child currently have any of the following symptoms (please discuss all that apply):**

Yes No

- ☐ ☐ Constitutional (fevers, chills, decreased appetite, weight loss, night sweats, tiredness, changes in sleep, recent trauma) ______________________________
- ☐ ☐ Respiratory (cough, shortness of breath, wheezing, coughing mucus) ______________________________
- ☐ ☐ Endocrine (excessive hunger, excessive thirst) ______________________________
- ☐ ☐ Cardiovascular (turning blue, chest pain, faintness, changes in heartbeat, loss of consciousness)______________________________
- ☐ ☐ Gastrointestinal (abdominal pain, nausea or vomiting, constipation, diarrhea, reflux, feeding difficulties, difficulty swallowing, bright red bleeding from rectum) ______________________________
- ☐ ☐ Hematologic/lymphatic (frequent nosebleeds, easy bruising, anemia, red or purple discolorations, excessive bleeding after dental work or injury) ______________________________
- ☐ ☐ Ears, Nose, Throat (runny nose, sinus pain, stuffy ear, ear pain, ringing in ears) ________________
- ☐ ☐ Genitourinary (painful urination, frequency, urgency, blood in urine, excessive, prolonged urination, hesitancy, waking at night to urinate, dribbling, decreased force of stream, incontinence)
- ☐ ☐ Musculoskeletal (joint pain, joint swelling, muscle pain, back pain, gait disturbance, decreased range of motion, popping or crackling sounds, functional deficit) ______________________________
- ☐ ☐ Skin (jaundice, rash, hives, itchiness, eczema, dryness or discoloration, abrasions, birthmarks) ____
- ☐ ☐ Neurological (changes in sight, smell, hearing or taste, seizure, altered consciousness, numbness, limb weakness, poor balance)______________________________
- ☐ ☐ Eyes (visual changes, headache, eye pain, double vision) ______________________________
- ☐ ☐ Allergic/Immunologic (swelling or pain at groin, armpits or neck, swollen lymph nodes/glands) ___
- ☐ ☐ Psychiatric (depression, anxiety, difficulty concentrating, changes in mental state) ______________
- ☐ ☐ Other:______________________________

6) **Please list all medications your child is taking (including prescription and over the counter):**

☐ None

____
____
____
____

7) **Is your child allergic to any medicines?**

YES NO

☐ ☐

NAME OF MEDICINE	**TYPE OF REACTION**
______________________________	______________________________
______________________________	______________________________

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8) **Is your child allergic to any foods?**

YES ☐ NO ☐

TYPE OF FOOD	TYPE OF REACTION
______________________	______________________
______________________	______________________

9) **Has your child ever had**:

YES	NO	
☐	☐	Urinary tract infections/kidney infections
		If yes, was there a fever? __________ How many infections? ______________________
☐	☐	Bedwetting/daytime wetting ______________________
☐	☐	Urinary frequency ______________________
☐	☐	Constipation ______________________
☐	☐	Kidney stones ______________________
☐	☐	Problems with the kidneys ______________________
☐	☐	Problems with the testicles ______________________
☐	☐	Problems with the penis ______________________
☐	☐	Problems with anesthesia ______________________
☐	☐	Problems with frequent nosebleeds or bruising ______________________

10) **Does anyone in your immediate family have any of the following:**

YES	NO	
☐	☐	Kidney problems______________________
☐	☐	Bladder problems ______________________
☐	☐	Bedwetting ______________________
☐	☐	Cancers ______________________
☐	☐	Bleeding disorders ______________________
☐	☐	Problems with anesthesia ______________________