DOERNBECHER CHILDREN'S Hospital
OHSU

Pediatric Urology Health History Form

Child's Name _____ Birthdate _____

Please complete this form as best you can and answer honestly. The answers you give are important in helping decide the best plan to treat your child.

1. Did your child go home from the hospital with you when he/she was born? No _____ Yes _____

2. Please tell us about any problems with your pregnancy or your child's birth. _____

   _____

3. Has your child ever been sick and had to stay the night in the hospital? No _____ Yes _____

   If yes, please tell us about this. _____

   _____

4. Has your child ever had surgery? No _____ Yes _____

   If Yes, please tell us what the surgery was for and date (or age your child was when it happened) _____

   _____

5. Please write any medications your child is taking now (including over-the-counter medications, herbs, and supplements). _____

   _____

6. Please tell us if your child has had any of these happen:

	No	Yes	If Yes, how old was your child when this happened?
Parents divorced			
Move to a new house or new city			
Death of a family member or friend			
Abuse of your child or another family member			
Other (new sibling, marriage of a parent, etc.)			

7. Does anyone have any concerns with your child's growth or development? No _____ Yes _____

8. Do you have any concerns with your child's emotions or behavior? No _____ Yes _____

9. Family History—please check if your child's family has ever had any of the following:

	No	Yes	If yes, which family member (mom, dad, brother, sister, etc)?
Daytime pee accidents			
Nighttime pee accidents (bed wetting)			
Kidney reflux (VUR)			
Hydronephrosis			
UTIs (urinary tract infections)			
Kidney stones			

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10. Has there ever been a time where your child was dry **both day and night** for 6 months or longer?
    No _____ Yes _____

11. Has your child ever had any of the following? (Please write the age your child was when this happened or write "ongoing" if it is still happening.

	No	Yes	Age when this happened or Ongoing
Constipation (big, hard, or painful poops, or doesn't poop every day)			
Peeing during the day often (more than normal)			
Peeing at night often (more than normal)			
Need to pee right away (urgently)			
Squatting to hold in pee			
Dribbling stream when peeing			
Painful peeing			
Extreme thirst			
Blood in pee			
Belly, back, or side pain			
Holding in poop			
Poop smears/streaks in underwear			

12. Has your child ever been diagnosed with a UTI (urinary tract infection)? No _____ Yes _____
    If yes, how many in the last year?_____ Did your child have a fever with any of these infections? _____

13. Does your child wear a Pull-up or diaper to bed? No _____ Yes _____
    If Yes, is the Pull-up/diaper wet or dry in the morning? Wet _____ Dry _____

14. Has your child every tried any of the following:

	No	Yes	Not Sure	If Yes, tell us about whether it worked or did not work.
Timed voiding (peeing on a schedule)				
Pelvic Floor Therapy				
TENS Unit				
Double-voiding/peeing				
Alarm watch for peeing				
Bed alarm for nighttime wetting				
Miralax or other constipation medications				
Ditropan (oxybutynin)				
Daily antibiotic to prevent UTIs				
Other				

15. Is there anything else you want your Pediatric Urology team to know about your child? _____

_____

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