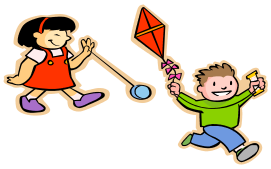
MOUNT SINAI SCHOOL OF MEDICINE

Pediatric Health Questionnaire

Patient Registration Form



Mount Sinai Medical Center
Pediatric Urology

Patient Name			Date
Date of Birth	Age	Sex ☐ Male ☐ Female	Weight lbs

History of Present Illness

Reason for being seen today (Chief Complaint)?

What symptom(s) does your child have? ☐ N/A

Does anything make the symptoms worse or better? ☐ N/A

How long have the symptoms been present? ☐ N/A

What tests have been done, if any? ☐ N/A

What treatments and/or medications have been (or were) given? ☐ N/A

Are there any other physical problems your child continues to have? (ear infection, cough, allergies, eye problems, dental problems, stomach pains, constipation, diarrhea, kidney infections, rashes, anemia, eating problems, etc.) ☐ N/A

Birth History

Pregnancy	Complications during pregnancy (infection, baby too small, poor movements)?	☐ Yes ☐ No	
Delivery	Was the baby premature?	☐ Yes ☐ No	
	Any complications after birth (jaundice, breathing, feeding problem, infection)?	☐ Yes ☐ No	

Hospitalizations and Illnesses

Please list any hospitalizations, surgeries, operations, serious illness, major accidents or injuries.

Age	Hospitalization/Major Illness or Injury

Allergies

Does your child have a MEDICATION allergy? ☐ Yes ☐ No	**Does your child have an allergy to foods, tape, dye, LATEX?** ☐ Yes ☐ No
Please list allergy	Reaction

Medications

Current Medications: Please list any medications your child is currently taking or takes often. Include prescriptions medications, over the counter medications or herbs.

Name	Dose (ml/tab/spoon)	Times per day

Previous Medications: Please list any medications your child used to take on a regular bases

Name	Dose (ml/tab/spoon)	Times per day

Immunizations: Is your child up to date for age? ☐ Yes ☐ No

Family History

Is there a family history of:

	Yes	No	Maternal	Paternal
Asthma	☐	☐	☐	☐
Allergies	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐
Seizures	☐	☐	☐	☐
Deafness	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Thyroid	☐	☐	☐	☐
Kidney Problems	☐	☐	☐	☐
Anemia/Bleeding	☐	☐	☐	☐

	Yes	No	Maternal	Paternal
High Blood Pressure	☐	☐	☐	☐
Gastrointestinal Disease	☐	☐	☐	☐
Birth Defects	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐
Heart Disease/Problems	☐	☐	☐	☐
T/B Cystic Fibrosis	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Slow Learner	☐	☐	☐	☐
Mental Illness (depression, etc.)	☐	☐	☐	☐

Do you have a family history of Kidney/Urological Problems? ☐ Yes ☐ No If "Yes" please describe:

Developmental/Social

Did you or do you now feel that your child was slow in his/her development of:

Speech/language	☐ Yes ☐ No	
Social Skills	☐ Yes ☐ No	
Motor Skills	☐ Yes ☐ No	
Does your child get along well with other children?	☐ Yes ☐ No	

Your previous medical records are important in providing us with a complete picture of your past medical history and current medical treatment. Did you bring them with you today? ☐ Yes ☐ No If not, please make arrangements to provide us with this information.

Filled out by: (please print) _____ Relationship: _____

Signature: _____ Date: _____

Clinician Signature: _____ Date: _____