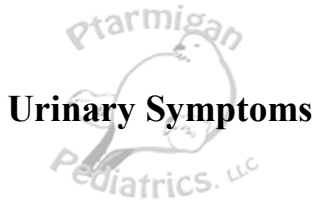


*Office Use Only*

VFC: [ ] V02 -- MDD  
 [ ] V03 -- No Ins  
 [ ] V04 -- Native  
 [ ] V07 -- AVAP

INSURANCE:  
 Copay / Co-ins \_\_\_\_\_

Statement Balance \_\_\_\_\_



## Urinary Symptoms

*Office Use Only*

WT: \_\_\_\_\_ kg \_\_\_\_\_ lb

HT: \_\_\_\_\_

Temp: \_\_\_\_\_

Resp: \_\_\_\_\_

Pulse: \_\_\_\_\_

Oxygen: \_\_\_\_\_

BP: \_\_\_\_\_

Is this a follow-up appointment? Yes / No.

Child's name: \_\_\_\_\_ Child's birthday: \_\_\_\_\_

Who is your child's primary care physician? \_\_\_\_\_

What is your concern today regarding your child? \_\_\_\_\_

### Symptoms

Abdominal pain yes/no. If yes, how long? \_\_\_\_\_

Urinary "accidents"? yes/no

Blood in urine? yes/no. If yes, how long? \_\_\_\_\_

Urgency urination? yes/no.

Frequent urination? yes/no.

Bedwetting? yes/no.

Painful urination? yes/no

### For Girls Only if Applicable

Last menstrual period was: \_\_\_\_\_

Periods started at age: \_\_\_\_\_

Any problems? \_\_\_\_\_

Does your child's urine have a smelly odor? yes/no.

How much water does your child drink daily? \_\_\_\_\_

### Review of systems:

Fever	yes/no. If yes, how long? _____	Dry skin	yes/no. If yes, how long? _____
Decreased appetite	yes/no. If yes, how long? _____	Rash	yes/no. If yes, how long? _____
Heartburn	yes/no. If yes, how long? _____	Joint pain	yes/no. If yes, how long? _____
Vomiting	yes/no. If yes, how long? _____	Sleep problems	yes/no. If yes, how long? _____
Diarrhea	yes/no. If yes, how long? _____	Is your child potty trained?	Yes / No / Attempting

Does your child have frequent UTI's? yes/no. If yes, please explain. \_\_\_\_\_

Does your child have a medication allergy? Yes/no. What medication/reaction? \_\_\_\_\_

Does your child have any chronic medical problems? Yes/no. If yes, please explain. \_\_\_\_\_

Has your child been admitted to the hospital overnight? Yes/no. If yes, please explain. \_\_\_\_\_

Has your child had any surgeries? Yes/no. If yes, please explain. \_\_\_\_\_

Is your child taking any daily prescribed medications? Yes/no. If yes, please explain. \_\_\_\_\_

Is your child taking any over-the-counter cold medications? Yes/No. If yes, please list: \_\_\_\_\_ Motrin or Tylenol? Yes/No

Does anyone in the family have:

Asthma? Yes/no please list: \_\_\_\_\_

Seasonal allergies? Yes/no please list: \_\_\_\_\_

Does anyone in the household smoke (inside or outside)? Yes / No. If yes, who? \_\_\_\_\_

Any pets? Yes / No. Which kind/how many? \_\_\_\_\_

Does your child attend daycare/school? (please circle) Where do they attend/what grade in school? \_\_\_\_\_

Are your child's immunizations up-to-date? Yes/no. If no, please explain. \_\_\_\_\_

This form completed by: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_ Today's Date \_\_\_\_\_