Office Use Only

VFC: [ ] V02 -- MDD
[ ] V03 -- No Ins
[ ] V04 -- Native
[ ] V07 -- AVAP
INSURANCE:
Copay / Co-ins

Statement Balance

Urinary Symptoms

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

Office Use Only

WT: _____kg _____ lb
HT: _____
Temp: _____
Resp: _____
Pulse: _____
Oxygen: _____
BP: _____

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**_____