Arkansas Children's Hospital

New Patient Information

❑ InStep Clinic ❑ Urology Clinic ❑ Urodynamics

Source of Information

Parents/Guardian: _____

Primary Care Physician:_____

Reason for today's visit

_____

History

Is the patient toilet trained? ❑ No ❑ Yes

If yes, at what age:_____

How many times does patient pee during the day?____

Does patient have full accidents? ❑ No ❑ Yes

If yes, how often?_____

Does patient leak urine in underwear? ❑ No ❑ Yes

If yes, before or after using bathroom?_____

Does patient strain to urinate? ❑ No ❑ Yes

Does patient have warning before urinating?

❑ No ❑ Yes

Does patient wet the bed? ❑ No ❑ Yes

If yes, when did this begin?_____

How many nights/week? 1 2 3 4 5 6 7

Does patient have urinary tract infections?

❑ No ❑ Yes

If yes, is fever present with them? ❑ No ❑ Yes

Does patient have a bowel movement daily?

❑ No ❑ Yes

Are bowel movements: soft hard loose

What does patient typically drink? _____

_____

Has patient been on any medicine for bladder, kidney or bowel problems? _____

Past Medical History

Allergies:_____

Current Medications:_____ _

_____ _____

_____

Has patient had any xrays, ultrasounds, or other tests of the kidney or bladder?_____

If so, where was it done?_____

Past Surgical History

Has patient had surgery? ❑ No ❑ Yes

If so, what/when?_____

Patient Name: _____

Patient Date of Birth: _____

Family History

Do any family members have kidney, bladder, or urological issues? Please explain.

_____

_____

Social History

Patient primarily lives with:_____

Is patient in daycare/school:_____

Patient's grade level:_____

Does patient have any new stressors? If so, describe:

_____

_____

Review of Systems

Has patient had any of the following problems?

Brain problems/seizures	Yes/No
Heart problems	Yes/No
Breathing problems	Yes/No
Sleeping/ Snoring problems	Yes/No
Stomach problems	Yes/No
Bladder/Kidney problems	Yes/No
Thyroid problems	Yes/No
Diabetes	Yes/No
Cancer	Yes/No
Bone/Muscle problems	Yes/No
Bleeding problems	Yes/No
Developmental problems	Yes/No

If yes, please describe:

_____

_____

_____

Further comments/information about today's visit:

_____

_____

Completed by: _____

Relationship to patient:_____