

UROLOGICAL WORK-UP FOR CHILDREN

Date _____

Name _____ Age _____ Hometown _____

Sex _____ Family Doctor _____ Referring Doctor _____

Drug Allergies _____ Current Medications _____

FAMILY HISTORY OF:

Kidney Trouble _____	Yes	No
Birth Defects _____	Yes	No
Diabetes _____	Yes	No

Prior Surgery (any kind) _____

Prior Kidney or Urinary Surgery _____

Prior Kidney X-Rays (IVP) _____

Has child ever seen an Urologist before? _____

ANY HISTORY OF:

High Blood Pressure _____	Yes	No
Glomerulonephritis _____	Yes	No
Back or side pain _____	Yes	No
Urinary Stones _____	Yes	No
Poor Weight gain _____	Yes	No
Fevers of unknown cause _____	Yes	No

IS THERE A PROBLEM OF:

Bed Wetting _____	Yes	No
Wetting during the day _____	Yes	No
Urinary Leakage _____	Yes	No
Painful urination _____	Yes	No
Straining to urinate _____	Yes	No
Blood in the urine _____	Yes	No
Weak or tiny urinary stream _____	Yes	No
Urinary frequency _____	Yes	No

MALES ONLY:

Is the urinary opening in the normal Position _____	Yes	No
Is the urinary opening of adequate size _____	Yes	No
Do the testicles swell _____	Yes	No
Are the testicles in normal position _____	Yes	No