Dear Parent or Guardian:

Thank you for scheduling an appointment with our practice. This letter confirms that _______ has an appointment on _______ in the following office.

____ CHKD (601 Children’s Lane, Norfolk) ____ Oak Brooke (500 Discovery Lane, Chesapeake)
____ Princess Anne (2021 Concert Dr, VB) ____ Oyster Point (11783 Rock Landing Dr, NN)
____ Williamsburg (6425 Richmond Rd, Williamsburg)

Please arrive at ___________. It is imperative that you arrive at the arrival time.

For your convenience, we have enclosed the following items:

✓ Map/directions for our CHKD locations
✓ Patient Questionnaire

Please complete all paperwork prior to arriving for your appointment. Because of the important medical information on the form, it must be provided before we can see your child.

Please bring the following items to your appointment:

✓ Any x-rays and lab reports done at any medical facility other than CHKD
✓ Completed patient questionnaire
✓ Insurance card and co-payment.
✓ Co-payment is required at time of visit. Please be advised we have the right to cancel your appointment if co-payment cannot be made at time of service.
✓ Referral from PCP if required by your insurance—Please be advised we have the right to cancel your appointment if the referral is not obtained.
✓ Any custody papers.

A parent or legal guardian must accompany the patient in order for us to render medical care. Please stop at our Central services registration area before going to the physician’s office. Please arrive 30 minutes prior to scheduled appointment. Parking is limited so please allow extra time.

If your child has been exposed to Mumps, Measles, Chickenpox or any other contagious disease in the last 21 days, please call our office before coming in.

If you are unable to keep your appointment, please call at least 24 hours in advance. There may be a charge incurred for missed appointments.

Self pay patients are expected to pay at the time of visit, please call for an estimate of charges. Customer service is important to us; you may receive a survey after your appointment please complete and return so we may improve our services.

Sincerely,

Physicians and Staff—Children’s Urology

Children’s Urology

Michael C. Carr, MD Charles E. Horton Jr, MD

Jyoti Ubedhay, MD Louis J. Wojcik, MD Malea Drummond, DNP, FNP-BC, CPN
Patient History Questionnaire-CSSG Children’s Urology

Date: ____________________

Patient Name:__________________________________________________________

Date Of Birth ______________________ Age _______ years, _______ months

Home PH _________________________ Cell PH ________________________________

E-Mail Address _________________________________________________________

Primary Care Physician (PCP) ____________________________________________

PCP’s Address __________________________________________________________

PCP’s Phone Number (______) ________________________________

_____________________________________________________________________

Name of person filling out form: __________________________ Relationship to patient: __________________________

Patient Accompanied By: ________________________________________________

What problem would you like us to evaluate today: ____________________________

Exposure within last 30 days: (circle) Measles Mumps Chicken Pox Tuberculosis Resistant Bacteria None Other: _____________

Prior Injuries: _ No _ Yes (please state type of injury, date and treatment): ____________________________

Prior X-rays: _ No _ Yes (please state type of x-ray and date): ____________________________

Prior Illnesses: _ No _ Yes (please state illness, dates, treatment and duration): ____________________________

Prior Surgeries _ No _ Yes (please state type of surgery and date): ____________________________

Current Injury Date: _________________ External cause of injury: _________________

Urological System History (specific intake): _________________

Age child toilet trained during daytime: ______

Currently during the daytime: 
Child is in  ☐ Underwear  ☐ Pullup  ☐ Diaper

Daytime child currently is: 

Completely dry  ☐ Yes ☐ No

Occasionally moist  ☐ Yes ☐ No

Damp underwear  ☐ Yes ☐ No

Soaks outer clothes  ☐ Yes ☐ No

Puddle of urine on ground  ☐ Yes ☐ No

Age child toilet trained during nighttime: ______

Currently during the nighttime 
Child is in  ☐ Underwear  ☐ Pullup  ☐ Diaper

Nighttime child currently is: 

Completely dry  ☐ Yes ☐ No

If not dry, how many nights per average week does child wet the bed? _______ /week

Child wakes up after wetting the bed  ☐ Yes ☐ No

Child gets up at night to urinate  ☐ Yes ☐ No

If yes, how many times per night _______

Child snores at night  ☐ Yes ☐ No

Child has sleep apnea  ☐ Yes ☐ No
Daytime Voiding Symptoms (check all that apply)

- □ Difficulty getting urine stream started
- □ Weak or poor urine stream
- □ Intermittent urine stream (stop, go, stop, go)
- □ Pushing or straining to urinate, pee, void
- □ Feelings of not completely emptying bladder
- □ Delays voiding until last minute
- □ Staccato (bursts) voiding

| Voids | □ Small | □ Large Amount | □ Just right |

Bowel Habits

How often does child poop? _______ times per □ day □ week

Does child have:

- Poop accidents in underwear
- Poop soiling of underwear
- Pain with pooping

| □ Yes | □ No |

Has child had any Urinary Tract (Bladder/Kidney) Infections?

□ Yes □ No

If yes, when, how often, and how treated?

______________________________

Additional comments regarding child's problem:

______________________________

Current Medications:

______________________________

Allergies:

Allergies to Medications? _ No _ Yes (please list medication and reaction to that medication!)

______________________________

Allergies to Food and Environmental? _ No _ Yes (please list reaction)

______________________________

Allergies to Latex? _ No _ Precautions Only _ Yes (explain reaction)

______________________________

Allergies to Metal Objects? _ No _ Yes (please list with reaction)

Past Medical History/Problems/Surgeries/Hospitalizations:

______________________________

School Information:

Name of School: ____________________________ Current grade: __________
Social History:

Hobbies/Sports/Activities: ________________________________

Who lives in the home: ________________________________

Developmental Milestones:

Rolling Over: _ No _ Yes, age: __
Sitting Up: _ No _ Yes, age: __
Crawling: _ No _ Yes, age: __
Walking: _ No _ Yes, age: __

Overall assessment: _ Within Normal Limits
_ Not Answered
_ Declined

Birth History:

Prenatal issues: ______________________________________

Was the pregnancy full term? _ No _ Yes

If no, number of weeks or months __________________________

Mode of Delivery: _ Vaginal _ C-section

Position: _ Vertex _ Breech

Any complications with the delivery? _ No _ Yes

If yes, explain _________________________________________

Birth Weight: __________________________ Comments: __________________________

Length at Birth: __________________________

Any complications during the newborn period? _ No _ Yes

If yes, explain _________________________________________

Is your child adopted? _ No _ Yes

Does your child have an identical twin? _ No _ Yes

Adolescent Health:

Menarche Onset: __________________________ Last Menstrual Period: ________________

Sexually active? _ No _ Yes _ Unknown

Types of Contraception/Protection? __________________________
## Family History

Please identify family medical history.

<table>
<thead>
<tr>
<th>Illness</th>
<th>Mother</th>
<th>Father</th>
<th>Sister</th>
<th>Brother</th>
<th>Maternal Grandmother</th>
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<td>Vesicoureteral Reflux</td>
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<td>Wilms Tumor</td>
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# Patient Review of Systems:

<table>
<thead>
<tr>
<th>System</th>
<th>Please Check All That Apply</th>
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</thead>
<tbody>
<tr>
<td>General</td>
<td>o NONE o Fatigue o Fever o Chills o Sweats o Change in Appetite o Fainting o Change in Sleep Habits o Weight Loss o Weight Gain o Bleeding Problems</td>
</tr>
<tr>
<td>Head</td>
<td>o NONE o Headaches o Recent Trauma</td>
</tr>
<tr>
<td>Eyes</td>
<td>o NONE o Decreased Vision o Pain o Itch o Dryness o Redness o Infection o Glaucoma o Double Vision o Glasses o Contact Lenses o Decreased Sense of Smell o Bleeding o Dryness o Pain o Discharge o Obstruction o Sinusitis o Seasonal Allergies</td>
</tr>
<tr>
<td>Nose &amp; Sinuses</td>
<td>o NONE o Decreased Sense of Smell o Bleeding o Dryness o Pain o Discharge o Obstruction o Sinusitis o Seasonal Allergies</td>
</tr>
<tr>
<td>Throat &amp; Mouth</td>
<td>o NONE o Sore Throat o Pain o Infection o Sore Tongue o Ulcers o Blisters o Lip Lesions o Canker Sores o Difficulty Swallowing o Hoarseness o Tonsillitis o Problems with Teeth</td>
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<tr>
<td>Neck</td>
<td>o NONE o Stiffness o Decreased Motion o Pain o Lumps o Swollen Glands</td>
</tr>
<tr>
<td>Breasts</td>
<td>o NONE o Discharge o Bleeding o Retraction o Tenderness o Size</td>
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<tr>
<td>Skin</td>
<td>o NONE o Rash o Itch o Color Change o Moles/Changes o Infections o Hair/Changes o Nails/Changes o Tumors o Sores o Hives</td>
</tr>
<tr>
<td>Respiratory</td>
<td>o NONE o Cough o Chest Pain o Wheezing o Asthma o Pneumonia o Sputum (Color/Frequency) o Recurrent Infection o Exposure to Tuberculosis o Cyanosis (bluish tint to skin, lips, nails) o Shortness of Breath on Exercise</td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>o NONE o Chest Pain o Murmur o Palpitations o Shortness of Breath o Difficulty Breathing o Fainting o Phlebitis o Varicose Veins</td>
</tr>
<tr>
<td>Lymphatic</td>
<td>o NONE o Anemia o Bleeding o Malignancy o Swollen Lymph Nodes o Transfusions</td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td>o NONE o Nausea o Vomiting o Vomiting Blood o Diarrhea o Heartburn o Food Intolerance o Change in Bowel Habits o Hernia o Constipation o Laxative/Enema Use o History of Ulcers o Abdominal Pain o Belching o Black Stools o Blood in Stools o Stooling “Accidents” o Bloating o Hemorrhoids o Nutritional Concerns</td>
</tr>
<tr>
<td>Genitourinary</td>
<td>o NONE o Burning o Inability to Start Stream o Infection o Urgency o Blood in Urine o Incontinence o Kidney Stones o Bedwetting o Daytime Urinary Leakage o Urinating Less Often o Urinating More Often o Toilet Trained, at what age</td>
</tr>
<tr>
<td>Male Reproductive</td>
<td>o NONE o CIRCUMCISED o Pain o Skin Lesions o Impotence o Testicular Pain o History of Sexually Transmitted Diseases</td>
</tr>
<tr>
<td>Female Reproductive</td>
<td>o NONE o Discharge o Itch o Infection o Started Menstrual Cycle o Painful Menstrual Cramps o Contraceptive Use o Complication of Pregnancy o History of Sexually Transmitted Diseases o Childbirth o Abortion o Painful Intercourse</td>
</tr>
<tr>
<td>Musculoskeletal</td>
<td>o NONE o Muscle Cramps o Pain o Weakness o Atrophy o Swelling o Joint Pain o Fracture o Back Injury o Curvature of Spine</td>
</tr>
<tr>
<td>Endocrine &amp; Metabolic</td>
<td>o NONE o Heat or Cold Intolerance o Weight Change o Diabetes o Hair Change o Excessive Sweating o Urinary Frequency o Voice Change o Excessive Thirst</td>
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<tr>
<td>Neurologic</td>
<td>o NONE o Headache o Fainting o Seizures o Dizziness o Blindness o Double Vision o Paralysis o Tremor o Pain o Numbness o Tic o Tingling Sensation o Burning Sensation o Lack of Coordination</td>
</tr>
<tr>
<td>Psychiatric &amp; Emotional</td>
<td>o NONE o Anxiety o Sleep Disturbances o Depression o Nervousness o Tension o Thoughts of Suicide o Emotional Instability o Delusions o Memory Loss o Hallucinations</td>
</tr>
</tbody>
</table>