Stony Brook Medicine

Department of Urology New Patient Intake Form—Pediatrics

Last Name_____ First Name_____
Date of Birth: ____/____/____ Social Security Number: _____

Referring Physician:_____ Phone #: _____

Physician Address: _____

Pharmacy:_____ Phone #: _____

Pharmacy Address: _____

History of Present Illness

Please answer the following questions

Chief Complaint

What is the main reason for your child's visit today?

☐ Urinary Tract Infections
☐ Proteinuria (Protein in Urine)
☐ Hydronephrosis
☐ Kidney Stones
☐ Urinary Frequency
☐ Urinary Incontinence
☐ Bedwetting
☐ Hydrocele
☐ Penile Adhesions
☐ Circumcision
☐Undescended Testis
☐ Other: _____

Which best describes your child's symptoms? Check all that apply.

- ☐ Frequent Urination—day, night, or both
- ☐ Sudden or strong urge to urinate
- ☐ Leakage with little or no warning----sometimes unable to make it to the bathroom in time
- ☐ Unable to completely empty the bladder-----feels like there is more even after going to the bathroom
- ☐ Accidental leakage with physical activity---exercising, sneezing, or coughing
- ☐ Bladder or pelvic pain
- ☐ Problems with bowel function (if checked, please select symptom below)
  - Accidental loss or leakage of stool
  - Constipation
  - Other
- ☐ No Bladder or bowel problems (if checked, please skip and continue to Past Medical History form)
- ☐ How long has your child had these symptoms? _____
- ☐ Has your child tried medications to help his/her bladder symptoms? ☐ Yes ☐ No
- ☐ If yes, how many different medications has he/she tried? _____

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Past Medical & Social History

Please answer the following questions

Medical History

Please check if **your child** has ever had any of the following:

☐ High Blood Pressure ☐ Lung (COPD, Asthma)
☐ Diabetes ☐ Thyroid
☐ GERD ☐ Seizures/Epilepsy
☐ High Cholesterol/triglyceride
☐ Sexually transmitted disease
☐ Cancer:
Type_____
☐ Kidney/Bladder (Renal Cyst, Renal Mass, Stones)
☐ Anxiety, depression or mental illness
☐ Blood disorders (abnormal bleeding anemia, high or low white count)
☐ Other _____
_____

Surgical History

1. Has your child ever had surgery? ☐ Yes ☐ No
2. Please list approximate dates and reasons for any surgery:

Date	Surgeries
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Allergies

Does your child have any allergies? ☐ Yes ☐ No

If yes please specify below:

_____ _____
_____ _____
_____ _____

Medications

1. Please list any prescription medications your child is currently taking and their dosage

Medication Name	Dosage	Reason for taking

2. Please indicate if your child is taking any of the following over the counter medications:

☐ Aspirin ☐ Tylenol ☐ Advil/Motrin/Ibuprofen
☐ Antacid ☐ Laxatives ☐ Decongestants
☐ Antihistamines ☐ Vitamins/Mineral Supplements
☐ Other: _____ _____
_____ _____

Family History

Please list all serious illnesses in your immediate family; (Example: Diabetes, Cancer, Tuberculosis, Heart disease)

Mother: Age_____ ☐ Living: _____
☐ Deceased-Cause: _____
Father: Age_____ ☐ Living: _____
☐ Deceased-Cause: _____
Sister: _____ _____
Brother: _____ _____

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Review of symptoms

Is your child currently having problems with the following? Circle yes (y) or no (N)

Constitutional Symptoms

Fever	Y|N
Chills	Y|N
Sweats	Y|N
Weakness	Y|N
Fatigue	Y|N

Eyes

Blurred Vision	Y|N
Double Vision	Y|N
Pain	Y|N

Immunologic

Recurrent Fevers	Y|N
Recurrent Infections	Y|N
Malaise	Y|N

Neurological

Confusion	Y|N
Numbness/Tingling	Y|N
Dizzy Spells	Y|N
Headache	Y|N

Endocrine

Excessive Thirst	Y|N
Too hot/Cold	Y|N
Excessive Hunger	Y|N

Gastrointestinal

Abdominal Pain	Y|N
Nausea/Vomiting	Y|N
Indigestion/heartburn	Y|N
Diarrhea	Y|N

Cardiovascular

Chest Pain	Y|N
Palpitations	Y|N
Ankle Swelling	Y|N

Physician Signature: _____

Date: _____

Integumentary

Skin Rash	Y|N
Boils	Y|N
Persistent itch	Y|N
Burns	Y|N
Skin Lesion	Y|N

Musculoskeletal

Joint pain	Y|N
Neck Pain	Y|N
Back Pain	Y|N

Ears/Nose/Throat/Mouth

Ear Infection	Y|N
Sore Throat	Y|N
Sinus Problems	Y|N

Genitourinary

Urine Retention	Y|N
Painful Urination	Y|N
Urinary Frequency	Y|N
Blood in Urine	Y|N

Respiratory

Wheezing	Y|N
Frequent Cough	Y|N
Shortness of breath	Y|N

Hematologic/Lymphatic

Swollen glands	Y|N
Blood clotting problems	Y|N
Bruising tendency	Y|N

Psychologic

Depression	Y|N
Anxiety	Y|N

Smart Medicine
STONY BROOK
UNIVERSITY HOSPITAL
STONY BROOK, NY 11794
Expert Care

Ambulatory Care
Consent and Notice of Privacy Practices
Acknowledgement Form

Patient Name: _____ Date of Birth: _____

MRN: _____ Enc#: _____

By signing below I consent to the use and disclosure of my health information to treat me and arrange for my medical care, to seek and receive payment for services given to me, and for the business operations of the Hospital and its staff. I have been provided a copy of the SBOHCA Joint Notice of Privacy Practices (Notice) and have therefore been advised of how health information about me may be used and disclosed by the Hospital and the facilities listed at the beginning of the Notice, and how I may obtain access to and control this information.

I acknowledge the receipt of the Ambulatory Care Patient Guide on, or prior to this visit.

_____
Signature of Patient or Patient Representative

_____
Print Name of Patient or Personal Representative

_____
Relationship, if signed by person other than Patient

_____ _____
Date Time

_____

_____ _____
Signature of Witness Print Name of Witness

_____ _____
Date Time

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Stony Brook Medicine

Ambulatory Care
Authorization to Discuss PHI with a Designee

Patient's Name: _____ Date of Birth: _____
(Please Print Clearly) (Please Print Clearly)

By signing below I hereby give permission to _____
(Name of Physician, Physician Practice or Service Practice)

to discuss with the following individuals information related the health care services I receive at the above named physician's office/physician practice. I agree that this information will be limited to appointment scheduling (date and time), procedure scheduling (date, time and preparation information) prescription re-fill(s), laboratory test results, radiology examination results and billing inquiries. I agree that this **does not** include the ability for the individuals noted below to authorize the disclosure of my protected health information to a third party or to request on my behalf a copy of my health information. I agree that this authorization will remain active until I revoke it by submitting an updated authorization to the physician practice noted above.

Name of Individual _____ Relationship to patient _____

Name of Individual _____ Relationship to patient _____

Name of Individual _____ Relationship to patient _____

Name of Individual _____ Relationship to patient _____

Name of Individual _____ Relationship to patient _____

Name of Individual _____ Relationship to patient _____

_____
Signature of Patient

_____ _____
Date Time

For Office Use Only

Patient's MRN _____

Date received: _____

This form is for office use only. Place in the correspondence section of the medical record. Not for release or disclosure.