DATE:___/___/20___

CHILD'S GU HISTORY FORM

PATIENT NAME:_____ DOB: _____

DOES YOUR CHILD HAVE, OR HAS HE/SHE HAD, ANY OF THE FOLLOWING SYMPTOOMS?
(PLEASE CIRCLE YOUR RESPONSE):

BEDWETTING?	YES	NO
BLOOD IN THE URINE?	YES	NO
DAYTIME WETTING OF CLOTHES?	YES	NO
FREQUENCY (URINATION MORE THAN NORMAL)?	YES	NO
HOW MANY TIMES AT NIGHT? _____		
HOW OFTEN DURING THE DAY? _____		
HAS HE/SHE EVER HAD KIDNEY X-RAYS (IVP, VCUG, ULTRASOUND, CYSTOGRAM)?	YES	NO
KIDNEY INFECTON (PYELONEPHRITIS)?	YES	NO
LOSS OF URINE (LEAKAGE, INCONTINENCE) WITH COUGHING OR SNEEZING?	YES	NO
LOSS OF URINE IF HE/SHE DOESN'T GET TO THE BATHROOM IMMEDIATELY?	YES	NO
PAIN IN THE BACK OR ABDOMEN, UNEXPLAINED BY ANOTHER ILLNESS?	YES	NO
PAIN OR BURNING WITH URINATION?	YES	NO
SKIN PROBLEMS/RASH IN THE GROIN/GENITAL AREA?	YES	NO
STONES IN THE KIDNEY OR BLADDER (NOT gallbladder)	YES	NO
URINARY TRACT INFECTION (UTI, BLADDER INFECTION)?	YES	NO
WEAK, DRIBBLING STREAM OR TOUBLE STARTING HIS/HER URINE?	YES	NO