MIU Pediatric Information

Patient Name: _____ Chart # / Office: _____

Home Phone: _____ Referring Physician: _____

Work Phone: _____ Date: _____

PLEASE ANSWER *ALL* QUESTIONS:

What is your reason for today's visit? _____

_____

GENERAL REVIEW OF SYSTEMS: Please answer each question listed below with a check mark on the line.

Is your child currently having any of the following?

Hearing Problems?	Yes ___ No ___	Fevers?	Yes ___ No ___	Constipation?	Yes ___ No ___
Painful Urination?	Yes ___ No ___	Back Ache?	Yes ___ No ___	Chest Pain?	Yes ___ No ___
Seasonal Allergies?	Yes ___ No ___	Skin Rashes?	Yes ___ No ___	Depression?	Yes ___ No ___
Bleeding Tendencies?	Yes ___ No ___	Headache?	Yes ___ No ___	Growth Problems?	Yes ___ No ___
Shortness of Breath?	Yes ___ No ___	Blurred Vision?	Yes ___ No ___		

Please describe any problem above or any other problem not mentioned: _____

_____

_____

MEDICATIONS:

Is your **child CURRENTLY** taking any medications? If yes, please list: _____

_____

Please list any ***allergies*** your child has to medications: _____

_____

What was the reaction? _____

_____

Does your child require medications or antibiotics before procedures? Yes___ No___

PAST MEDICAL / FAMILY / SOCIAL HISTORY: (Please Check all that apply and provide information below)

Does YOUR CHILD have a history of:		Premature Birth	Yes___No___	Eating Problems	Yes___No___
HIV Exposure	Yes___No___	Diabetes	Yes___No___	High blood Pressure	Yes___No___
Heart Disease	Yes___No___	Asthma	Yes___No___	Heart Valve problems	Yes___No___
Kidney Disease	Yes___No___	Cancer	Yes___No___	Spinal Cord Problems	Yes___No___
Lung Problems	Yes___No___	Hepatitis	Yes___No___		

Has **anyone in your FAMILY** had:		Cancer	Yes___No__	Heart Problems	Yes___No__
		Kidney Disease	Yes___No__	Diabetes	Yes___No__

SOCIAL HISTORY:

Does anyone in the home smoke? Yes___No__ Did the birth mother receive prenatal care? Yes___No__

_____

_____

Please list **YOUR CHILDS** Medical Problem / Surgical History: (Give approximate dates for surgeries / hospitalization.)

Major Medical Problems	**Past Surgeries / Hospitalizations**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Patient Signature: _____ **Physician Signature:** _____

Form Completed By: _____ **Relation** _____ **Date** ____/____/____

OFFICE USE ONLY

ROS CHANGES:

Constitutional ________ Cardiovascular________ Respiratory________
Skin________ Hem/Lymph________ Psych ________
Neuro________ Eyes________ GI________
ENT________ Musc/Skel________ Endo________
Allergy/Imm________

PFSH: Meds:________ Other:________
PERSONAL:________
FAMILY:________
SOCIAL:________

UPDATED BY: ________ **Date**____/____/____

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UPDATED BY: ________ **Date**____/____/____

MICHIGAN INSTITUTE OF **UROLOGY**

NOTICE OF PRIVACY PRACTICES

PATIENT ACKNOWLEDGEMENT

Please sign this form below to acknowledge that you have received a copy of the Privacy Statement from Michigan Institute of Urology.

Patient Signature _____ Patient Name (printed) _____

Date _____

DESIGNATION OF PERSONAL REPRESENTATIVE

As required by the Health Information Portability and Accountability Act you have a right to nominate one or more persons to act on your behalf with respect to the protection of health information that pertains to you. By completing this form you are informing us of your wish to designate the named person as your personal representative. You may revoke this designation at any time by completing the revocation form. You may obtain this form from the front desk personnel.

Please note: This form does not grant permission to release medical records to these designated representatives. Requests for medical records must be made separately.

Name	Relationship	Phone Number
Name	Relationship	Phone Number
Name	Relationship	Phone Number

Patient Signature _____ Date _____