Cook Children's Medical Center

Date _____

Patient Name: _____ DOB: _____

Name of person completing form:_____

Relationship to patient:_____

Primary Care Physician: _____

Referring Physician: _____

Preferred Pharmacy: _____

Reason For Today's Visit

Please list the reason for your child's visit to the nephrology clinic.

_____

_____

Birth/Social History

Length Of Pregnancy: _____ Birth Weight: _____

Were there any birth complications that you are aware of?

_____

_____

Does your child have any developmental delays?

_____

_____

Is your child adopted? ◯ Yes ◯ No

Who does your child live with? _____

Have there been any recent changes to your child's family or social situation? ◯ Yes ◯ No
If yes, please explain:

_____

_____

_____

Patient Medical History

Has your child ever been treated for any of these medical problems?

Medical Problem	Yes/No	If Yes, Please Explain
Asthma/Recurrent Wheezing		
Blood Clotting Disorder		
Blood Transfusion		
Cancer		
Chromosomal Abnormality		
Chronic Illnesses		
Congenital Abnormality		
Deafness		
Diabetes		
Ear/Hearing Problem		
Epilepsy		
Eye Problems		
Heart Problems		
High Blood pressure		
Hospitalizations		
Kidney Stones		
Muscle, Joint, Or Bone Problem		
Neurological Or Seizure Problems		
Recurrent Urinary Tract Infections		
Other		

Immunizations up to date? _____Yes _____ No

Please list any other concerns about your child that we should be aware of.

_____
_____
_____
_____

Current Medications

Please list any medications that your child is currently taking including over the counter medications.

Medication	Dose	Medication	Dose

Allergies

Please list any allergies that your child has along with the reaction from exposure.

Allergy	Reaction

Past Surgical History

Please list any previous surgeries that your child has had along with the date of surgery.

Surgery/Procedure	Date Of Surgery/Procedure

Serious Injuries

Please list any serious injuries that your child has been treated for.

Serious Injury	Date Of Injury

Family History

Do any relatives of your child (mother, father, siblings, grandparents, aunts, uncles, etc) have any of the following medical problems?

Medical Problem	Yes/No	If Yes, Who	Age Diagnosed
Anemia			
Bed Wetting			
Bleeding Disorders			
Bright's Syndrome			
Congenital Abnormalities			
Deafness			
Diabetes			
Dialysis			
Heart Attack			
High Blood Pressure			
Kidney Disease			
Kidney Failure			
Kidney Stones			
Kidney Transplant			
Recurrent UTI's			
Other			