JOHN MUIR HEALTH

100 N. WIGET LANE, SUITE 290, WALNUT CREEK, CA 94598 - (925) 937-7740, FAX (925) 933-9868
2222 EAST STREET, SUITE 250, CONCORD, CA 94520 - (925) 609-7220, FAX (925) 689-3298
5201 NORRIS CANYON RD, SUITE 210, SAN RAMON, CA 94583 - (925) 830-1140, FAX (925) 973-0976
2400 BALFOUR RD, SUITE 230, BRENTWOOD, CA 94513 - (925) 937-7740, FAX (925) 933-9868

Urology New Patient (Pediatrics)

Patient Name:_____ Date of Birth:_____Today's Date: _____
First Middle Initial Last

Reason for your visit today? Be precise.

Physician that referred you for care at John Muir Urology: _____

Pediatrician: _____

PEDIATRIC HISTORY

Height: _____	**Date:** ___/___/___ Month Day Year

Weight: _____	**Date:** ___/___/___ Month Day Year

PRENATAL

Pregnancy:

Complications?	**YES** ❑	**NO** ❑	If YES, please explain:

Delivery:

Gestational Age:

Vaginal ☐ C Section ☐ (please explain reason):

CHILD'S PAST MEDICAL HISTORY	**YES**	**NO**	**COMMENTS**
Diabetes	☐	☐	
High Blood Pressure	☐	☐	
Kidney Disease	☐	☐	
Heart Problems	☐	☐	
Developmental Concerns	☐	☐	
Anemia	☐	☐	
Diarrhea	☐	☐	
Constipation	☐	☐	
Cancer	☐	☐	
Lung Problems	☐	☐	
CHILD'S PAST SURGICAL HISTORY	**YES**	**NO**	**Procedure/Date**
Circumcision	☐	☐	
Tonsils	☐	☐	
Testicle Surgery	☐	☐	
Kidney Surgery	☐	☐	
Hernia	☐	☐	
Appendix	☐	☐	
Bladder Surgery	☐	☐	
Heart Surgery	☐	☐	

Patient Name:_____ Date of Birth:_____Today's Date: _____
First Middle Initial Last

FAMILY HISTORY

RELATION	AGE(S)	STATE OF HEALTH	IF DECEASED, CAUSE/AGE OF DEATH
Mother			
Father			
Siblings			
Are you of Ashkenazi Jewish	**YES** ❑ **NO** ❑		

Please list any diseases that run in your family, such as cancer, kidney stones, diabetes, etc.

Disease	Family member

REVIEW OF SYSTEMS

Has your child experienced any of these problems

	YES	NO		YES	NO
Constitutional Symptoms:			Hematologic:		
Fevers			Easy bruising		
Chills			Bleeding Disorder		
Headaches			Allergic:		
Eyes			Allergies		
Poor vision			Hay Fever		
Head and neck:			Neurologic:		
Hearing loss			Seizures		
Sore throat			Muscle Weakness		
Cardio Vascular:			Genital:		
High Blood Pressure			Hernia		
Heart Murmur			Testicle Problems		

Patient Name:_____ Date of Birth:_____Today's Date: _____
First Middle Initial Last

Respiratory:			Hypospadias		
Cough			Developmental:		
Asthma			ADHD		
Gastrointestinal:			Depression		
Constipation			Anxiety		
Diarrhea			Age Potty Trained:		
			Age Menses Began:		
Broken Bone					

SOCIAL HISTORY

GRADE IN SCHOOL:	
SCHOOL ATTENDING:	
LIVING WITH:	❑MOM❑DAD ❑BOTH ❑OTHER:
LEGAL GUARDIAN:	❑MOM❑DAD ❑BOTH ❑OTHER:
	If other does that person have legal documents allowing for medical treatment? ☐ YES ☐ NO
CIGARETTE USE:	☐YES ☐NO
ALCOHOL USE:	☐YES ☐NO

Patient Name:_____ Date of Birth:_____Today's Date: _____
First Middle Initial Last

CURRENT MEDICATION

DRUG NAME	DOSE	FREQUENCY	PRESCRIBING PHYSICIAN

ALLERGIES

☐ **No Known Allergies** ☐ Penicillin ☐ Codeine ☐ Sulfa ☐ Cipro ☐ Macrobid

MEDICATION	SPECIFIC TYPE OF REACTION

CONSENT TO ACCESS MEDICATION HISTORY

In order to provide you with the best possible care, your prescriptions will be written electronically whenever possible. Electronic prescribing is now a common practice due to healthcare initiatives requiring the use of electronic medical records. With your permission, e-prescribing will provide us access your medication history electronically, enabling us to see critically important information on your current and past prescriptions, better assess potential medication issues, and improve safety and quality of care.

By signing below I give my consent to John Muir Health to access my medication history electronically and to the best of my knowledge, I verify that the above medical information is complete and correct. I understand that it is my responsibility to inform my physician if I ever have a change in my health.

*** **SIGNATURE**: Patient or Legally Authorized Individual	Date
Print Name	If Signed on Behalf of Patient, Relationship to Patient

PREFERRED OUTSIDE PHARMACY

Name & Address (Location) of Preferred <u>OUTSIDE</u> Pharmacy: Is this is a MAIL ORDER PHARMACY?

❑ **Yes** ❑ **No**

Please list a local pharmacy for urgent prescriptions if primary is a mail order. Name & Address of LOCAL pharmacy: