UF UNIVERSITY of FLORIDA

PEDIATRIC NEPHROLOGY, PEDIATRIC MULTISPECIALTY CENTER

Patient Name:_____
Date of Birth_____
MRN: _____
Date: _____

Does patient have any?	Yes (circle)	No
Fever, Wt loss, decrease appetite		
Pink eye, decrease vision, deafness		
Sore throat; mouth ulcers, baldness		
Rapid heart beat, chest pain		
Shortness of breath, cough		
Nausea/vomiting/Diarrhea, abd pain		
Urinary frequency, urgecy, buring, dysuria, flank pain, bed wetting		
Limp, joint pain, swelling, limitation of motion, tenderness		
Rash, scar, birth mark		
Change in sensorium, lethargy		
Allergies, sinusitis, facial swelling		

Past History: (if yes, When?)

Kidney problem: NO YES
_____
Surgeries: NO YES
_____
Injuries: NO YES
_____
Urinary tract Infections: NO YES
_____
Hospitalization NO YES
_____
Any medical problem?
_____

Family History: (circle the positive history)

High blood pressure	Diabetes	Kidney failure
Dialysis	Kidney stone	Hearing Loss
Lupus	Psoriasis	Crohn disease
Rheumatoid arthritis	Chronic pain	Vision loss
Blood in urine	Over weight	

Social History:

Living with parents	NO	YES
Pets at home	NO	YES
Day Care	NO	YES
Sick contact	NO	YES
Smoking	NO	YES
Drug/Alcohol Use	NO	YES
Sexual Activity	NO	YES

School grade: Performance:

Growth and Development

Up to date NO YES
Developmental delay, NO YES
Speech difficulty, NO YES
Physical limitation NO YES

Immunization History:

Up to Date NO YES
_____

Birth History

Born Full term premature (weeks)_____

Normal C section

Birth Weight _____lb _____oz
Complications _____
_____
_____
_____

Medications:

1. _____
2. _____
3. _____
4. _____

Allergies:

- ❑ Medication_____
- ❑ Food _____

Primary Care Physician information

Name _____

Address_____
_____
_____

Phone: _____
Fax: _____