Patient Name: *(Place Sticker Here)*

DOS:______________

PSA#:__________________

******MD Use ONLY******

----PSA Exam Form-FEMALE----

History of Present Illness *****To Be Completed by MD*****

Where (specifically) is pt experiencing s/s?

Onset of s/s: ☐ Birth ☐ Other: ________________________________

How many times/how frequently does pt experience s/s? ☐ Constant ☐ Intermittent
Hourly Daily Weekly Monthly Other:

How intense/severe is s/s? ☐ Mild ☐ Moderate ☐ Severe

Precipitating event/s prior to onset?

Other related s/s?

Previous treatment/therapy or other that helps or relieves the s/s?

☐ WNL **Orientation**--------------See Dictation________________
☐ WNL **Mood/Affect**-------------See Dictation________________

☐ **W/D, W/N Female-----------------See Dictation**________________
Height: _______ Weight: ________ T _______ P ________ RR ________ BP ________/_________
☐ **WNL Abdomen-------------See Dication**________________
☐ **WNL Back---------Hypertrichosis________Cleft________Other**________________
☐ **WNL Hernia----------------See Dictation**________________
☐ **WNL Liver/Spleen---------See Dictation**________________

Female GU System Tanner: 1 1-2 2-3 3 3-4 4 4-5 5
☐ **WNL Ext. Genit.------------See Dication**________________
☐ **WNL Meatus----------------See Dictation**________________
☐ **WNL Bladder---------------See Dictation**________________
☐ **WNL Anus/Perineum-----See Dictation**________________
☐ **Not indic.-------Urethra------See Dictation**________________
☐ **Not indic.-------Vagina-------See Dictation**________________
☐ **Not indic.-------Cervix--------See Dictation**________________
☐ **Not indic.-------Uterus--------See Dictation**________________
☐ **Not indic.-------Adnexa-------See Dictation**________________
☐ **Not indic.-------DRE-----------See Dictation**________________
☐ **Not indic.-------Breast---------See Dictation**________________
☐ WNL **LE Reflexes**-------------See Dictation________________
☐ WNL **Skin**-----------------------See Dication________________
☐ WNL **Thyroid**-------------------See Dication________________
☐ WNL **Chest (auscult)**---------- See Dictation________________
☐ WNL **Cardiac (auscult)**--------See Dication________________
☐ WNL **Lymph (axilla/groin)**----See Dication________________

Data Reviewed: ***Radiology*** *Personal Review of Scan/Image* ______ ***Clinical Labs*** _______	***Billing Based on Time?*** ***Total Visit Time:*** _______ **Time spent in Counseling & Coord. of Care** ____________________	MD Initial & Date ___________
Format Date: 4/29/09 — ***Surgery? Yes No***		

Pediatric Surgical Associates
*****Patient Intake Form *****
Pediatric Urology

Place Label Here

Patient Name: **DOB:** **Date of Visit:**

Reason for today's visit:

Review of Systems (Are you currently experiencing…):

Constitutional Problems:
- Fevers/Chills Yes No
- Headaches Yes No
- Other________________________

Eye Problems:
- Needs Glasses Yes No
- Other________________________

ENT (Ears, Nose, Throat) Problems:
- Ear Infections Yes No
- Congestion/Sinus Yes No
- Other________________________

Endocrine (Gland) Problems:
- Excessive Thirst: Yes No
- Too hot/cold Yes No
- Other________________________

Cardiac (Heart) Problems:
- Turning blue Yes No
- Palpitations yes No
- Other________________________

Pulmonary (Breathing) Problems:
- Wheezing/coughing Yes No
- Other________________________

GI (Gastrointestinal) Problems:
- Constipation Yes No
- Diarrhea Yes No
- Nausea/Vomiting Yes No
- Other________________________

Psych Problems:
- Depression Yes No
- Anxiety Yes No
- Other________________________

Muscle/Joint Problems:
- Back Pain Yes No
- Leg Pain Yes No
- Other__________________________

Neurologic Problems:
- Learning Problems Yes No
- Other__________________________

Heme(Blood)/Lymph Problems:
- Blood Transfusions Yes No
- Clotting Problems Yes No
- Swollen Glands Yes No
- Other__________________________

Skin Problems:
- Frequent Rashes Yes No
- Other _________________________

Urologic Problems: (Please circle answer. If not applicable, leave blank.)

Bladder/Kidney/Urinary Tract infections?--------------No	Yes	How often?___________________		
Fever with these infections?------------------No	Yes	Highest Temp:________________		
Pain when urinating?--------------------------------------No	Occasionally	Frequently		
Blood in the urine?--No	Yes (on urine test)	Yes (visible)		
Toilet trained?---No	Yes	At what age?___________________		
Leak urine during the day?-------------------------------No	Rarely	Occasionally	Frequently	
Get up to urinate at night?--------------------------------Never	Rarely	Occasionally	Frequently	
Wet the bed?---Never	Rarely	Occasionally	Frequently	
When she needs to urinate, is it **sudden**?--------------Never	Rarely	Occasionally	Frequently	

How often does she urinate during the day?________________

Allergies to (Seasonal, Dietary, etc.):______________________________What is the reaction? ____

Current Medications:
____
____

Medication Allergies & Reaction:
____

Weight:______________ **Height:**______________

Past Medical History (Please circle all that apply):

Neurologic	Seizures	ADD/Hyperactivity	Syndromes/Chromosomal/Other Problems
Endocrine (Gland)	Diabetes	Glaucoma	____________________________________
Pulmonary (Breathing)	Asthma/Wheezing	Pneumonia	____________________________________
Cardiac (Heart)	High Blood Pressure	Congenital Heart Disease	____________________________________
Gastrointestinal	Crohn's/UC	GE Reflux	
Infections	Hepatitis	Tuberculosis (Tb)	

Problems (for child) during Pregnancy____

Baby Born at: ______ weeks (40 is normal) Birth Weight?______________ Problems at birth?______________________________________

Past Surgical History: ____

Family Medical History:

Problems (for mother) during pregnancy:_________________________Drugs/medications taken during pregnancy:_______________________

Urology family history:____

Abnormal reactions to anesthesia____

Bleeding disorders____

Social History:

Child lives: At Home In a Foster Home In a Facility_________________________________

Child lives with: Mother Father Guardian/Relative

Any siblings in family? Yes No If yes, how many and ages____

Does child attend school? Yes No What grade? __________________ Alcohol/Tobacco/Drugs Yes No

Activities/Interests____

MD Comments:____

MD Initial & Date signifying Review of ROS & PFSH____________________

Form Format Date: 4/29/2009