UROLOGY
MICHAEL C SOLOMON
M.D., P.A., F.A.C.S.

Patient's Name: _____ Date: _____
(last) (first)

Age: _____ DOB:_____ Referring Pediatrician _____

What is the main reason for your visit today? Write in your own words on the lines provided:
_____
_____

Yes/ No
Has your child been seen by any other Urologist? ☐/☐ If yes, Who? _____

Is your child allergic to:

___ Latex _____Dye _____ IV Contrast ☐ Shellfish____ Shrimp ☐ Iodine _____ Betadine ____ Tape / Adhesives
____Anesthetics _____Penicillin _____ Sulfa _____ Cipro / Levaquin

N.K.D.A _____ Other Medication allergies:

What is the name & number of your pharmacy preference: _____

Current Medications (including over the counter)

Has your child had any surgical procedures?

Has your **SON** had a circumcision? Yes / No At birth? Yes / No If no, what age _____ By Whom? _____
Is your child up to date with his/ her Immunizations? Yes / No
What is your child's current weight? _____ Height?_____

	Yes	No
Does your child currently have any of the following problems? Please circle		
Urinating more frequently than usual?	☐	☐
Wetting the bed at night?	☐	☐
Daytime wetting of clothes?	☐	☐
Urinary tract infections?	☐	☐

If yes how many in the last 6 months? _____ Who treated them? _____

	Yes	No
Leakage of urine if he/ she doesn't get to the bathroom immediately.....	☐	☐
Burning with urination?	☐	☐