New Patient Intake Form for Pediatric Endocrinology

Name:_____ **DOB**_____

	Yes	No
Has your child ever been hospitalized overnight? (If yes, list dates and reason below)	□	□
Has your child ever had surgery (If yes, list dates and reason below)	□	□
Does your child have any chronic medical problems? (if yes, list below)	□	□
What was our child's weight at birth:_____		
Was the pregnancy full term (at least 37 weeks)	□	□
If no, how many weeks were you at delivery?_____		
Were there any complications with your child at the time of delivery?	□	□
Was your child in the NICU after being born?	□	□
Was the mother diabetic during the pregnancy?	□	□
Was the delivery a vaginal or C-Section?	□	□
Did your child go thru their developmental milestones on time?	□	□
What grade is your child in? _____		
Who does your child live at home with? _____		
If your child has siblings, are they healthy? (If not, please list healthy issues below)	□	□

Is your child allergic to anything? (if yes, please list below)	□	□
Are your child's vaccines up to date?	□	□
Is your child taking any medications/vitamins/supplements? (If yes, list below)	□	□

_____

Family History (if your child is adopted and you do not have the biological parents' information, disregard the following questions)

Mother: What is your ethnicity? _____
How tall are you?_____
How old were you with your first period? _____
Do you have any medical issues? (if yes, please list) _____

Father: What is your ethnicity? _____
How tall are you?_____
Did you go thru puberty at an average age or do you feel you were an early or late bloomer?
_____
Do you have any medical issues? (if yes, please list) _____

Is there any diabetes or thyroid disease in the family? If yes, please list below which relative and there medical condition._____

_____

Female Patients:	**Yes**	**No**
Has your child had their period ever?	□	□

If yes, when was their last date of the period? _____

All Patients:

Does your child suffer from frequent fevers?	□	□
Does your child suffer from frequent fatigue?	□	□
Is your child drinking more than normal lately?	□	□
Is your child bothered by the hot weather more than other people?	□	□
Is your child bothered by the cold weather more than other people?	□	□
Has your child ever suffered a seizure?	□	□
Does your child suffer from frequent headaches?	□	□
Does your child have any visual problems?	□	□
Does your child were corrective lenses?	□	□
Does your child snore?	□	□
Does your child have episodes where he or she stops breathing at night or gasps for air?	□	□
Does your child suffer from Asthma?	□	□
Does your child have frequent or current cough?	□	□
Does your child have chest pain?	□	□
Does your child have heart palpitations?	□	□
Does your child suffer from frequent constipation?	□	□
Does your child suffer from frequent diarrhea?	□	□
Does your child suffer from frequent nausea?	□	□
Does your child suffer from frequent vomiting?	□	□
Does your child have any difficulty or pain urinating?	□	□
Does your child have any blood in their urine?	□	□
Does your child have any broken bones?	□	□
Does your child suffer from acne, dry skin, or other rashes?	□	□

Does your child have any depression, mood, or behavior problems? □ □