Endocrinology new patient appointment – Diabetes/high blood sugar

Patient label

Welcome to the clinics of the Division of Pediatric Endocrinology at the University of Kentucky. Please help us to get to know you better by completing this form. If you are uncertain about any answer, please leave it blank and we will discuss it later. ***Please bring this paperwork with you to your first appointment.***

Child's Full Name: _____
Birth Date: _____Age: _____ Sex [] Male [] Female

Name and address of the provider who referred your child to our clinic:
_____
_____
Primary Care Provider (if different than above): _____

Reason for referral to Endocrinology Clinic: _____
_____

MEDICAL HISTORY

Allergies (please list all food, drug or environmental allergies)**:** _____
_____

What type of diabetes does your child have? _____Age at diagnosis: _____
Have you participated in a diabetes education class before? [] Yes [] No
Is yes, When _____ Where _____ Who attended _____

Has your child had: [] Asthma [] Chicken pox [] Head injury [] Seizures
Has your child been hospitalized before? [] Yes [] No
If yes, please provide date, hospital, and reason:_____
_____
Has your child ever had surgery? [] Yes [] No
If yes, please provide date, hospital, and reason: _____
_____
Has your child had any additional medical problems in the past? [] Yes [] No
If yes, please explain _____
Are your child's immunizations up to date? [] Yes [] No [] Not sure

BIRTH HISTORY

Was your child born [] At due time [] Early [] Late
Birth weight: _____ Birth length: _____
Were there any problems during pregnancy, labor, or delivery? [] Yes [] No
If yes, please describe. _____
Did the baby stay in the hospital for a health problem after birth? _____
Did your child have any difficulties with feeding or growing during the first few months of age?
_____

SOCIAL HISTORY

What grade is your child in? _____ Name of school? _____County? _____
How is your child's school performance? _____
How many school days has your child missed in this current school year? _____
Are there any special concerns or problems you have related to school? _____

FAMILY HISTORY

Please provide the following information about your ***child's*** ***immediate family members***:

Family Member:	Age	Height	Weight	Significant health problems
Brothers:				
Sisters:				
Mother:				
Mother's mother:				
Mother's father:				
Father:				
Father's mother:				
Father's father:				

Do any members of your family have the following medical conditions (including grandparents, aunts, and uncles?)

Diabetes [] No [] Yes (List relation) _____
Thyroid disease [] No [] Yes (List relation) _____
Growth problems [] No [] Yes (List relation) _____

Please list any medical conditions that tend to run in your family: _____
_____
_____

Are there any other problems related to hormones in your family (calcium problems, parathyroid problems, kidney stones, etc.)? If so, please list:_____
_____

CURRENT MEDICATIONS

Please be prepared to discuss your child's insulin and supplies with the diabetes educator

Drug: Dose: Ordered by:

_____
_____
_____
_____
_____
_____

HYPOGLYCEMIA (LOW BLOOD SUGAR)

Does your child wear/carry a medical alert ID? [] Yes [] No

Does your child carry something to treat a low blood sugar with them?

[] At all times [] Usually [] Rarely [] Never

What symptoms does your child usually have with a low blood sugar?

_____

Has your child ever had a seizure or lost consciousness due to a low blood sugar? [] Yes [] No
Do you have Glucagon at home? [] Yes [] No
Who knows how to use it? _____
When and how would you use Glucagon? _____
_____
Approximately how many times have you used Glucagon for your child? _____

HYPERGLYCEMIA (HIGH BLOOD SUGAR)

Do you know what diabetic ketoacidosis (DKA) is? [] Yes [] No
Has your child ever been to the E.R. or admitted to a hospital for elevated blood sugars or DKA?
[] Yes [] No If yes, when? _____

EXERCISE

Does your child get regular exercise (20 minutes per day, 3 times per week)? [] Yes [] No
Does your child participate in after-school activities and sports? [] Yes [] No
If so, describe the type, frequency, and duration of activity: _____
_____

COMPLICATIONS

Does your child use tobacco? [] Yes [] No [] Unknown
If so: Packs per day? _____ Number of years smoked? _____
Does your child use alcohol? [] Yes [] No [] Unknown
If so: How much? _____ How often? _____

Does your child have regular dental visits? [] Yes [] No

Does your child have any of the following complications? Check all that apply.

Cardiovascular:	[] High blood pressure	
	[] Stroke	
Eye:	[] Retinopathy	Date of last eye exam: _____
	[] Glaucoma	
	[] Cataract	
Kidney:	[] Microalbumin	Date of last 24-hour urine: _____
	[] Urine protein	
	[] Kidney failure	
Neuropathy:	[] Digestive tract	
	[] Feet problems:	[] Pain [] Ulcers [] Ingrown nails [] Calluses

COPING

What part of diabetes care does your child perform? _____
_____
What part of diabetes care is most difficult for you and/or your child? _____
_____

In what ways has diabetes interfered with your normal lifestyle? _____
_____

PEDIATRIC ENDOCRINOLOGY
SYMPTOM CHECKLIST

The purpose of this checklist is to help identify important symptoms that relate to your child's overall health and well-being. In our clinic, we will address those issues which impact your child's growth, pubertal development and/or endocrine system.

DOES YOUR CHILD CURRENTLY HAVE ANY OF THE FOLLOWING PROBLEMS?

	YES	NO	COMMENT
Visual trouble or eye problems			
Ear problems or hearing difficulty			
Frequent headaches			
Frequent dizziness or loss of balance			
Weakness			
Increasing fatigue			
Shortness of breath			
Fast heart rate			
Frequent stomach aches			
Frequent vomiting			
Frequent diarrhea			
Frequent constipation			
Blood in urine or stools			
Change in appetite			
Excessive thirstiness			
Excessive or increasingly frequent urination			
Frequent urination at night			
Bedwetting			
Urinary tract infection			
Early/late development of puberty			
Irregular periods			
Vaginal discharge			
Muscle or joint pain			
Skin rash, itching or bruising			
History of broken bones			
Allergy to a medication or food			
Change in school performance – better/worse			
Change in mood or behavior			
Change in sleep pattern			
Recent stress or pressures at home or school			

When was your child last seen by his or her pediatrician or family doctor for a well-child visit?

_____

Parent/Guardian Signature: _____Date:_____

Provider signature: _____ Date: _____