

Endocrinology new patient appointment – Diabetes/high blood sugar

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: _____