Patient label

Endocrinology new patient appointment – Not diabetes

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): _____
Name and address of other providers who can provide important medical information about your child, including past height and weight measurements:

_____

_____

Reason for referral to Endocrinology Clinic: _____

_____

When did you first become aware of the problem? _____
Has there been any change in the nature/severity of the condition since you initially noticed?
[] None [] Increased [] Decreased [] Other _____
Are there any other blood-relatives with a similar complaint, past or present? [] Yes [] No
If yes, please list whom, relation, and when: _____

_____

MEDICAL HISTORY

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

_____

Has your child had: [] Asthma [] Diabetes [] 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

CURRENT MEDICATIONS

Drug: Dose: Ordered by:

_____

_____

_____

_____

Has your child taken medicine in the past for more than three weeks? Please list those medicines and the reason why they were prescribed.

_____

_____

BIRTH HISTORY

Was your child born [] At due time [] Early [] Late
Gestational age if early or late: _____
Method of delivery: [] Vaginal [] Induced [] Forceps [] Other: _____
[] C-section (reason): _____
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? _____

Please check any of the following that applied during pregnancy with this child:
[] High blood pressure [] Use of alcohol [] Use of illegal drugs
[] Smoking [] Use of medications [] High blood sugar
[] Other:_____

NUTRITION HISTORY

The child was: [] Breast fed [] Formula fed [] Both [] For how long? _____

Did your child have any difficulties with feeding or growing during the first few months of age?

_____

SOCIAL & DEVELOPMENTAL HISTORY

Preschoolers: Did your child meet average milestones? (walking, talking, sitting-up, etc.)
[] Yes [] No
School age: What grade is your child in?_____
Name of school? _____ County? _____
How is your child's school performance? _____
Are there any special concerns or problems you have related to school? _____

_____

PUBERTAL DEVELOPMENT

When did your child first have signs of puberty? _____

_____
Please describe what signs: _____

_____
For females: What age did your child start her period? _____ [] Not applicable

(A) What is the duration of her period? _____ days, and how far apart are the cycles? _____
(B) When was her last menstrual cycle? _____
(C) List any problems associated with periods: _____

FAMILY HISTORY

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

Family Member:	Age	Height	Weight	Age when started puberty	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:_____
_____

SYMPTOM CHECKLIST

On the next page is a checklist of a variety of medical symptoms. Please complete this checklist by identifying any current symptoms which you feel are significant.

Thank you for taking the time to complete this information. Please remind your pediatrician or family physician to send a copy of your child's medical records and previous growth charts to our office. If you have any home records of your child's growth (for example, baby books, school reports, home measurements), these can also be very helpful in evaluating growth-related medical problems. Feel free to bring this information with you to your appointment.

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: _____