Endocrine Associates of Dallas, P.A.

Diplomates of the American Board of Internal Medicine and the Subspecialty Board of Endocrinology and Metabolism

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PEDIATRIC PATIENT HEALTH HISTORY

Please fill in the blank lines or mark with a check where appropriate:

I. Contact Information

Name of Patient:_____ Boy ____ Girl ____
Nickname:_____ Date of Birth: _____ Age:_____ School grade level:_____
Street Address:_____Apt.#_____
City:_____State:_____ZIPCODE: _____
Home Phone:_____

Name of Parent(s) or Legal Guardian(s): _____
Street Address:_____Apt.#_____
City:_____State:_____ ZIPCODE:_____
Home Phone:_____Work Phone:_____Cell Phone:_____

Does child live with parent(s)/legal guardian(s)? Yes____ No____
If no, please provide name(s) of such person(s):_____
Relationship to patient:_____ Home Phone:_____
Work Phone:_____Cell Phone:_____

Other Emergency contact person:_____Relationship:_____
Address:_____
City:_____State:_____ZIPCODE:_____
Phone#:_____ Alternate Phone#:_____

Pharmacy name & address:_____Phone#:_____

II. PATIENT'S REASON FOR OFFICE VISIT:_____

_____
_____

III. General Information:

1. Is your child involved in any special activities? (sports, school clubs, youth groups, toddler/preschool programs, etc.) No____ Yes ____ If yes, please describe briefly: _____
_____
_____

2. Is your child involved in regular physical activity? No____ Yes____
If yes, what type? _____How often?_____

[III. General Information -- continued from page 1]

3. Please indicate (check) your child's type of diet:

☐ Balanced (all nutrition groups) ☐ Diabetic ☐ Vegetarian
☐ Gluten Free ☐ Low Fat ☐ Lactose Intolerant ☐ Vegan
☐ Other: Please explain_____

4. Does your child have any body piercings: Yes☐ No☐ AND/OR tattoos: Yes☐ No☐

5. Does your child:
Smoke: Yes☐ No☐ Not sure☐
Drink Alcohol: Yes☐ No☐ Not sure☐

IV. Medications

Has your child had a recent influenza vaccination? Yes: ☐ Date:_____ No ☐

Has your child had all recommended vaccinations for his/her age? No ☐ Not sure ☐
Yes ☐ Date of last immunization: _____

Does child take medications? Yes ☐ No ☐ Vitamins or supplements? Yes ☐ No ☐

Please list any known drug allergies or other negative reactions to medications: None ☐
_____
_____

Please list all diabetes medications separately on Pages 7 and 8, in section III "for a child with diabetes."

Below, please list all other medications including inhalers, vitamins and supplements.

Medication Name	Dose (mg, ml, sprays, etc.)	Frequency (per day, per week, etc.)	Age Started (or give date)
1.			
2.			
3.			
4.			
5.			
6.			

V. BIRTH HISTORY: (if child is adopted, please provide as much information as is known)

1. Child is adopted Yes ___ No ___

2. Mother's age at child's conception:_____years

3. Was conception natural or assisted?_____

4. Were there complications during pregnancy? Yes ___ No ___ If yes, please explain: _____
_____
_____

5. Did mother take medication during pregnancy? Yes ___ No ___ If yes, please explain: _____
_____
_____

5. Did mother smoke during pregnancy? Yes___ No ___

6. Was pregnancy full term? Yes ___ No ___ If no, indicate number of months or weeks:_____

7. Conditions of child's delivery:
   "Normal"/vaginal: Yes ___ No ___ C-section: Yes ___ No ___
   Forceps: Yes ___ No ___ Vacuum: Yes ___ No ___
   Cord around baby's neck: Yes ___ No ___ Multiple births (twins, etc.) Yes ___ No ___

8. Child's birth information: Weight: ____lbs/ ____oz. Length: _____Inches
   Apgar Scores (if known): _____

VI. Developmental History:

Please indicate age of child at the time of the following milestones:

First began crawling:	_____months
First step:	_____months
First word:	_____months
First tooth:	_____months
First tooth lost:	_____years
Start of pubertal changes:	_____years
Girl's first menstrual period:	_____years

VII. FAMILY HEALTH -- If patient is adopted, or family history is unknown, check here: ☐

Please provide the following information:

Mother's date of birth:_____Height:_____Weight:_____Age at puberty:_____
Father's date of birth: _____Height:_____Weight:_____Age at puberty:_____

Is child here to be evaluated for delayed growth (being a "late bloomer") ? Yes ☐ No ☐ If yes, please tell us if any other member of the patient's immediate family (siblings, parents, grandparents) was also late in developing in the teenage years and, if so, which family member(s):_____
_____

Family Health History:

Please check all that apply	Father	Mother	Grandfather		Grandmother		Aunt		Uncle	
			Paternal	Maternal	Paternal	Maternal	Paternal	Maternal	Paternal	Maternal
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Thyroid Problems	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Kidney Problems	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Cancer **Type of Cancer:**	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Sibling information--

Please check whether sibling is a brother or sister and fill in the information for each:

Brother	Sister	Date of Birth	Age at Puberty	History of Serious Illness
☐	☐			
☐	☐			
☐	☐			
☐	☐			
☐	☐			

VIII. CHILD'S HEALTH REVIEW:

Please list any major surgeries and child's age at the time: ***[if none, check here ☐]***

1. _____Age:_____
2. _____Age:_____
3. _____Age:_____
4. _____Age:_____

Please list any major illnesses: ***[if none, check here ☐]***

1. _____Age at diagnosis:_____
2. _____Age at diagnosis:_____
3. _____Age at diagnosis:_____
4. _____Age at diagnosis:_____

OVERALL HEALTH REVIEW -- Please check all conditions that apply:

GENERAL

- Fever ☐
- Chills ☐
- Unusual Fatigue ☐
- Weakness ☐
- Nervousness ☐
- Fainting ☐
- Anemia ☐
- Pain ☐
- Sleep Problems ☐
- Food Allergies ☐
- Rapid Weight Changes ☐
- Unusual Sweating ☐
- Emotional or Psychological Issues ☐
- Seizures or Convulsions ☐

EARS/NOSE/THROAT/RESPIRATORY

- Hearing impairment ☐
- Hearing aid use ☐
- Ringing in ears ☐
- Neck pain ☐
- Difficulty swallowing ☐
- Hoarseness/Cough ☐
- Sinus Infections ☐
- Nosebleeds ☐
- Asthma ☐
- Allergies ☐

URINARY TRACT

- Infection ☐
- Pain when Voiding ☐
- Frequent Urination ☐
- Blood in Urine ☐
- Kidney Stones ☐

EYES

- Vision changes ☐
- Vision loss ☐
- Pain when Looking at light ☐
- Unexplained Eye pain ☐
- Cataracts ☐
- Eye injuries ☐

HEAD

- Dizziness ☐
- Headaches ☐
- History of Head Injury ☐
- Stroke ☐

SKIN

- Rashes ☐
- Itching ☐
- Hives ☐
- Easy Bruising ☐
- Changes in Hair ☐

ENDOCRINE and METABOLIC SYSTEMS REVIEW

I. General review -- Please check all conditions that apply:

For Boys and Girls:

- Rapid weight change ☐
- Heat intolerance ☐
- Cold intolerance ☐

For Girls Only:

- Irregular menstrual periods ☐
- Excessive facial or body hair ☐

II. <u>For patients with thyroid problems</u> -- please mark with a check if child has the following:

Enlarged thyroid	Yes___	No___
Thyroid nodule(s)	Yes___	No___
Underactive thyroid	Yes___	No___
Overactive thyroid	Yes___	No___
Thyroid cancer	Yes___	No___

III. <u>For a child with diabetes</u> -- please complete the following section:

1. General information:

Age of Diagnosis _____ Date of last eye exam:_____
Date of last microalbumin_____ Results (check one): Normal____Abnormal____
Date of last Hgb A1C _____ Value:_____%
Do child use a glucose meter? (check one) Yes____ Brand name:_____ No____
Frequency of blood sugar testing_____times per day.
Blood sugar range_____
Does patient use a CONTINUOUS GLUCOSE MONITOR (CGM)? Yes____ No____

2. For patients using oral medication only OR using oral medication plus insulin:

List oral medications: 1._____Dose_____
2._____Dose_____
3._____Dose_____
4._____Dose_____

Does child use oral medication plus insulin? Yes____ No____
If yes, please provide the following information:
Long acting insulin -- Brand:_____
Time of day and amount for each:_____
Short acting Insulin -- Brand:_____
Time of day and amount for each:_____
Pre-mixed Insulin -- Brand:_____
Time of day and amount for each:_____

For patients using oral medication plus insulin:
Is the insulin dose adjusted?_____If so, by what method? _____
_____

3. For patients injecting insulin only -- please provide the following information:

Long acting insulin -- Brand:_____
Time of day and amount for each:_____
Short acting Insulin -- Brand:_____
Time of day and amount for each:_____
Pre-mixed Insulin -- Brand:_____
Time of day and amount for each: _____

Is the insulin adjusted?_____ If so, by what method?_____
_____

4. For patients using an insulin pump -- please provide the following information:

Brand of pump: _____Date started:_____
Basal Insulin Rates: _____
Insulin/Carb Ratio: _____
Insulin Correction Factor:_____

* * * * *

I AFFIRM THAT THE INFORMATION PROVIDED ON THIS FORM IS CORRECT TO THE BEST OF MY KNOWLEDGE.

Signature of Parent or Guardian:_____ Date: _____
OR:
Signature of Authorized Representative_____Date: _____
Please print representative's name:_____
Relationship to patient:_____

Thank you for completing this health history form. The information is important and will help Endocrine Associates of Dallas to better serve your health care needs. If you have questions, please be sure to discuss them with us during your office visit.