NEW PATIENT

All information is treated as confidential

Please type or print available information. Today's date_____

Patient's full name (first middle surname suffix):

_____

Patient's nickname(s)_____ | Patient's date of birth_____

Patient's age ____ years & _____ months | Sex (circle): M F | Gender: M F _____

(circle or indicate) Mother's / Stepmother's / Grandmother's / Legally Authorized Representative's full name:

_____

(circle or indicate) Father's / Stepfather's / Grandfather's / Legally Authorized Representative's full name:

_____

Patient's complete home address_____

_____

Indicate your preferred call order, starting with the first number to call.

Cell number with area code_____ Whose cell? □ mother □ father □ _____

Cell number with area code_____ Whose cell? □ mother □ father □ _____

Work number with area code_____ Whose work? □ mother □ father □ _____

Home phone with area code_____

Referring practitioner/group_____

Referring practitioner's/group's address_____

_____

Referring practitioner's/group's phone with area code_____, fax_____

Referring practitioner's/group's email_____

Referring practitioner's/group's web portal https://_____

REASON(S) FOR VISIT

□ constitutional delay | late bloomer
□ idiopathic short stature | poor growth
□ growth hormone deficiency
□ failure to thrive
□ HYPERthyroidism (Graves's disease)
□ Hashimoto's thyroiditis
□ other acquired HYPOthyroidism
□ specify other reason

□ type 1 diabetes mellitus
□ type 2 diabetes mellitus
□ insulin resistance without diabetes
□ delayed puberty | late bloomer
□ precocious (early) puberty
□ premature adrenarche
□ premature thelarche

□ vitamin D deficiency
□ failed newborn screen
□ congenital hypothyroidism
□ congenital adrenal hyperplasia
□ panhypopituitarism
□ Addison's disease
□ hypoparathyroidism

_____

CHIEF COMPLAINT (in patient's or parent's own words)_____

_____

_____

_____

_____

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Review of Systems by recent or current symptoms (circle all that apply to ***only*** the patient)

Constitutional:	negative	fatigue	lethargy	heat intolerance	cold intolerance
Head, eyes, ears, nose, throat:	neg	blurred vision	hoarseness	neck fullness	
Respiratory:	neg	snoring	apnea	unusual breathing	
Cardiovascular:	neg	chest pain	short of breath with exercise		
Gastrointestinal:	neg	nausea	vomiting	constipation	diarrhea
Genitourinary:	neg	bedwetting	painful urination	groin/pelvic pain	waking at night to urinate
Neurology:	neg	headaches	blackouts	seizures	spasticity
Musculoskeletal:	neg	limp	knee/hip pain	joint swelling	frequent fractures/bone pain
Blood/Lymphatic:	neg	anemia	bleeding	bruising	chronic infections
Allergy/Immunology:	neg	rhinitis	sinusitis	seasonal allergies	lymph node enlargement
Integument:	neg	rash	folliculitis	dark nape of neck	dark armpits
Behavioral:	neg	depression	anger	anxiety	disruptive behavior
	insomnia				
Endocrine:	neg	nocturia	bedwetting	excessive urination	excessive thirst
	weight loss		weight gain	weight stable	
	shortest child in class			heaviest child in class	

Female, breast development onset:	none	before age 5	6	7	8	9	10	11	12
Female, first menses onset:	none	before 5	6	7	8	9	10	11	12
Male, deodorant needed since:	none	before 5	6	7	8	9	10	11	12

Male, any breast enlargement (gynecomastia): □ none □ if yes, first noticed when and by whom? _____

_____

Gynecomastia is now… □ mild □ moderate □ severe □ affecting both breasts

Past Medical History

Birth weight_____ kg, or ____ pounds & _____ ounces | Birth length_____ cm, or _____ inches

Head circumference at birth_____ cm, or _____ inches

Complications during pregnancy: □ none □ if yes, describe_____

_____

Birth location (e.g., hospital name & address)_____

Complications during delivery: □ none □ if yes, describe_____

_____

Complications in nursery: □ none □ if yes, describe_____

_____

Past Surgical and Procedure History

□ general surgery	□ abdominal surgery	□ elective circumcision	□ other (specify):
□ ear tube(s)	□ cleft lip	□ dental surgery	
□ tonsillectomy	□ adenoidectomy	□ appendectomy	
□ heart surgery	□ inguinal hernia repair	□ congenital heart symptoms	

In which facility and when was each procedure performed? Attach discharge summary or extra pages as needed.

_____

_____

_____

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ALLERGIES □ none □ if yes, list symptom(s) and trigger(s):

Latex allergy: □ No □ YES

Were allergies were confirmed by allergist? □ no □ if yes, then whom, where, when? _____

CURRENT MEDICATIONS (list name, dose, route of administration, frequency, prescriber, start date; attach page if needed) *EXAMPLE ONLY: loratadine 10 mg by mouth once daily, John Smith MD, San Antonio allergist, 11Apr2012*

PAST MEDICATIONS (list name, dose, route of administration, frequency, prescriber, start date; attach pages as needed) *EXAMPLE ONLY: 1. tetanus booster vaccine by injection, Jane Doe NP, Austin primary care, 12Apr2016*

BIOLOGICAL FAMILY HISTORY

Biologic mother's age_____ y | height: □ unknown, _____ cm or _____ inches, □ self-reported or □ measured

Biologic mother's weight: □ unknown, _____ kg or _____ pounds, □ self-reported or □ measured in clinic

First period (menses onset) at age_____ years | Describe any health issues_____

highest education _____ | occupation_____

Biologic father's age_____ y | height: □ unknown, _____ cm or _____ inches, □ self-reported or □ measured

Biologic father's weight: □ unknown | _____ kg or _____ pounds, □ self-reported or □ measured in clinic

Final height at age_____ y | Describe any health issues_____

highest education _____ | occupation_____

Patient's oldest sibling (full name)_____ Age_____ y | Sex: M F

Height_____ cm, or _____feet _____inches | Weight _____ kg or _____ pounds

Patient's next oldest sibling (full name)_____ Age_____ y | Sex: M F

Height_____ cm, or _____feet _____inches | Weight _____ kg or _____ pounds

Patient's next oldest sibling (full name)_____ Age_____ y | Sex: M F

Height_____ cm, or _____feet _____inches | Weight _____ kg or _____ pounds

Patient's next oldest sibling (full name)_____ Age_____ y | Sex: M F

Height_____ cm, or _____feet _____inches | Weight _____ kg or _____ pounds

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Paternal grandmother's age_____, □ now □ at death | Height_____ in or _____ cm, □ reported vs. □ measured

Menses onset: □ unknown □ at age ____ | current health status_____

Paternal grandfather's age_____, □ now □ at death | Height_____ in or _____ cm, □ reported vs. □ measured

Adult height at age ____ | current health status_____

Maternal grandmother's age_____, □ now □ at death | Height_____ in or _____ cm, □ reported vs. □ measured

Menses onset: □ unknown □ at age ____ | current health status_____

Maternal grandfather's age_____, □ now □ at death | Height_____ in or _____ cm, □ reported vs. □ measured

Adult height at age ____ | current health status_____

□ specify adoptions_____

□ adult females shorter than 4 feet and 11 inches (≈150 cm), who and how short?_____

_____

□ adult males shorter than 5 feet, 4 inches (≈163 cm), who and how short?_____

_____

□ adult females taller than 5 feet, 9 inches (≈176 cm), who and how tall? _____

□ adult males taller than 6 feet, 3 inches (≈191 cm), who and how tall? _____

□ "juvenile" type 1 diabetes; who and age at diagnosis? _____

□ type 2 diabetes; who and age at diagnosis? _____

_____

□ thyroid condition; who, kind, age at diagnosis? _____

□ cancer; who, kind, age at diagnosis? _____

□ high cholesterol; who, kind, age at diagnosis? _____

□ high blood pressure; who, age at diagnosis? _____

□ early heart attack, or □ early stroke, or □ early death; who and what age?_____

_____

Please describe positive family history in more detail or attach pages as needed_____

_____

_____

Race/ethnicity of biologic mother_____, biologic father_____, patient_____

PERSONAL HISTORY

Patient lives with (check all who apply) □ parents □ grandparents □ guardian □ mother □ father
□ foster parent □ siblings □ others; who and where? _____

In school? □ no □ if yes, grade level_____ | recent school performance: □ good □ fair □ poor

School name and location_____
□ regular classes □ resource classes □ daycare before or after school □ home school

Activities: □ sedentary □ sports □ dance □ art □ music □ video games □ reading □ others_____

_____

LIFESTYLE HISTORY

How many ounces of sodas, sweetened beverages, and fruit juices does your child (or you) drink each day?
_____ounces per day Are you willing to work on this area? □ yes □ no

NEW PATIENT

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How many meals does your child (or you) eat at home each week? _____meals per week
Are you willing to work on this area? □ yes □ no

How many days each week does your child (or you) play outside or exercise for at least 60 minutes?
_____days/week Are you willing to work on this area? □ yes □ no

How often does your child (or you) take second helpings?
mark one: □ almost never □ not often □ sometimes □ often □ always
Are you willing to work on this area? □ yes □ no

How many days each week does your child (or you) eat breakfast?_____days per week
Are you willing to work on this area? □ yes □ no

How many hours each day does your child (or you) spend watching TV or playing video/computer games? Please do not include computer use for homework. _____hours per day
Are you willing to work on this area? □ yes □ no

If your child or anyone in your household uses *tobacco* in any form, please specify who, the form of tobacco, how much, and how often_____

If your child or anyone in your household uses *alcohol* in any form, please specify who, the form of alcohol, how much, and how often_____

If your child or anyone in your household uses *recreational drugs* in any form, please specify who, the form of recreational drug, how much, and how often_____

If patient has been sexually active, was this: □ consensual □ non-consensual (attach additional pages as needed)
If patient uses birth control, please describe_____

DIABETES THERAPY

"Sugar Surfing"? □ Yes □ Trying to Sugar Surf □ Not yet, but I want to learn more (www.sugarsurfing.com)

Insulin by vial and syringe

Typical clock time and dose for breakfast_____

Typical clock time and dose for lunch_____

Typical clock time and dose for supper/dinner_____

Typical clock time and dose for bedtime_____

Pump settings

Insulin type/brand_____

Basal rate(s) and time(s)_____

_____

Insulin to carbohydrate ratio for boluses_____

_____

Pump brand and model_____

CGM brand and model_____

Blood glucose meter brand_____ | Blood sugar is usually checked _____ times per day.
Did you bring your child's (or your) glucose log? □ Yes! No, because I… □ do not keep one □ forgot to bring it
□ rely on CGM, brand and model_____
□ rely on a meter, brand and model _____

Is the insulin refrigerated? □ YES □ no

Does patient have glucagon at home? □ YES □ no Has the glucagon expired? □ NO □ yes

Does patient skip meals? □ NO □ yes

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Does patient use glucose patterns? □ no □ YES

Is diabetes well controlled (e.g., hemoglobin A1c <7%)? □ YES □ no

Most recent hemoglobin A1c?_____% Date?

Does patient miss insulin shots? □ NO □ yes; how often?_____

Does patient self-inject? □ YES □ no

Does patient rotate insulin injection sites? □ YES □ no

Does patient take extra doses of insulin? □ no □ If YES, please describe _____

_____

Does the patient recognize mild hypoglycemia? □ YES □ No

Does patient carry rescue glucose with him/her? □ YES □ If no, why not?_____

If patient ever required glucagon to treat severely low blood sugar, please describe when and what happened:

_____

If your child has (or you have) experienced night time hypoglycemia over the last 3 months, please describe:

_____

Does patient check for ketones when ill? □ YES □ If no, why not?_____

Does patient/family know and have printed sick day rules? □ YES □ If no, why not?_____

_____

Specify diabetes care supplies needed today:

□ application for medical identification tag □ glucagon □ alcohol pads □ sharps box □ log book

□ insulin brand(s)_____

□ insulin pump supplies, specifically_____

_____

□ glucose test strip brand_____

□ insulin syringes, specifically gauge and size_____

□ ketone strip brand_____

□ lancet brand_____

□ 504 plan (please provide template if available)

□ diabetes camp form (please provide form if available)

□ TSA letter for travel (please provide form if available)

Specify other issues_____

_____

_____

_____