NEW PATIENT

All information is treated as confidential

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 _____

□ Mother's, □ Stepmother's, □ Grandmother's, □ Guardian's, or □ Legally Authorized Representative's full name:

_____

□ Father's, □ Stepfather's, or □ Grandfather's full name:

_____

Patient's (child'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, or_____

Cell number with area code:_____ Whose cell? □ mother, □ father, or_____

Work number with area code:_____ Whose work? □ mother, □ father, or_____

Work number with area code:_____ Whose work? □ mother, □ father, or_____

Home phone with area code:_____

VISIT INFO:

Name of primary care provider (PCP):_____

Name of 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://_____

Preferred pharmacy (name, address, voice, fax, email): _____

_____

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 HYPOthyroidism
□ other acquired HYPOthyroidism
□ overweight, obesity, and/or PCOS
□ type 1 diabetes mellitus
□ type 2 diabetes mellitus
□ insulin resistance without diabetes
□ delayed puberty | late bloomer
□ precocious (early) puberty
□ premature adrenarche
□ premature thelarche
□ specify other:_____
□ vitamin D deficiency
□ failed newborn screen
□ congenital hypothyroidism
□ congenital adrenal hyperplasia
□ panhypopituitarism
□ Addison's disease
□ hypoparathyroidism

CHIEF COMPLAINT:_____

_____

_____

NEW PATIENT

All information is treated as confidential

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

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		self-harm		
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…	never	before age 5	6	7	8	9	10	11	12
Female: First menses onset…	never	before 5	6	7	8	9	10	11	12
Male: Deodorant needed since…	never	before 5	6	7	8	9	10	11	12

Male: Any breast enlargement (gynecomastia): NO If yes, first noticed when?_____

Who first noticed the gynecomastia?_____

Gynecomastia is now… mild moderate severe affecting both breasts

Past Medical History:

Birth Weight: _____ kg, or _____ pounds & _____ ounces | Birth Length: _____ cm, or _____ inches

Complications during pregnancy: □ none □ If YES, describe:_____

Complications during delivery: □ none □ If YES, describe:_____

Complications in nursery: □ none □ If YES, describe:_____

Past Surgical History:

□ general surgery	□ abdominal surgery	□ elective circumcision	□ body piercings
□ ear tubes	□ cleft lip	□ dental surgery	□ other:
□ tonsillectomy	□ adenoidectomy	□ appendectomy	_____
□ heart surgery	□ inguinal hernia repair	□ congenital heart symptoms	

Where and when were each surgery or procedure performed? Attach summary or additional pages as needed.

ALLERGIES: □ No □ If YES, list symptom(s) and trigger(s):

NEW PATIENT

All information is treated as confidential

Latex Allergy: □ No □ YES

Were allergies were confirmed by allergist? □ No □ If YES, who, where, when? _____

_____

CURRENT MEDICATIONS (list name, dose, route of administration, frequency, prescriber, start date)

AS EXAMPLE ONLY: loratadine 10 milligrams by mouth once daily, Dr. John Smith, allergist in San Antonio, February 2012

_____

_____

_____

_____

_____

PAST MEDICATIONS (list name, dose, route of administration, frequency, prescriber, start date)

AS EXAMPLE ONLY: tetanus booster vaccine by subcutaneous injection, Dr. Jane Doe, primary care in Houston, April 2014

_____

_____

_____

_____

Family History (make additional pages as needed)

Biological mother's age_____ | height: □ unknown, _____ cm, or _____ inches, □ reported or □ measured

Biological mother's weight: □ unknown, _____ pounds, or _____ kg, □ reported or □ measured

Age with first period (menses onset): _____ years | final height at age:_____ y | Describe any health issues:

_____

highest education_____ | occupation_____

Biological father's age_____ | height: □ unknown, _____ cm, or _____ inches, □ reported or □ measured

final height at age:_____ y | Describe any health issues:

_____

Biological father's weight: □ unknown, _____ pounds, or _____ kg, □ reported or □ measured

highest education_____ | occupation_____

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

Height: _____ feet ____ inches, or _____ cm | Weight _____pounds, or _____kg

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

Height: _____ feet ____ inches, or _____ cm | Weight _____pounds, or _____kg

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

Height: _____ feet ____ inches, or _____ cm | Weight _____pounds, or _____kg

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

Height: _____ feet ____ inches, or _____ cm | Weight _____pounds, or _____kg

Paternal grandfather's age_____now or □ at death | Height _____inches or ____ cm, □ reported vs. □ measured

Attained adult height at age_____ □ unknown | Current health status_____

NEW PATIENT

All information is treated as confidential

Paternal grandmother's age_____now or □ at death | Height _____inches or ____ cm, □ reported vs. □ measured
First period at age_____ □ unknown | Current health status_____

Maternal grandfather's age_____now or □ at death | Height _____inches or ____ cm, □ reported vs. □ measured
Attained adult height at age_____ □ unknown | Current health status_____

Maternal grandmother's age_____now or □ at death | Height _____inches or ____ cm, □ reported vs. □ measured
First period at age_____ □ unknown | Current health status_____

Comments_____

Family History of:

□ male relatives shorter than 64 inches or female relatives shorter than 59 inches; who and how short? _____

_____

□ tall stature, 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? _____

□ high blood pressure

□ early heart attack □ early stroke □ early death

Please describe positive family history in more detail as needed: _____

_____

Self-reported race/ethnicity of father_____, mother_____, patient_____

PERSONAL HISTORY

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

Is child in school: □ no □ YES grade: _____ | recent school performance: □ good □ fair □ poor

School name and location: _____

□ regular classes □ resource classes □ daycare before or after school □ home school □ charter school

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

details such as hours per week_____

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

How many home-prepared meals does your child (or you) eat each week? _____home-prepared 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 per 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

NEW PATIENT

All information is treated as confidential

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 the patient has been sexually active, was this: □ consensual □ if non-consensual, how was it reported:

_____

If patient uses birth control, please describe form or brand, dates of therapy, and prescriber(s):

_____

INSULIN THERAPY

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

□ ***Vial and syringe, or*** □ ***pen needle***

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… □ rely on CGM □ rely on a meter □ forgot to bring it □ do not keep one

If your child has (or you have) ever required glucagon injection 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 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

NEW PATIENT

All information is treated as confidential

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

Does patient use glucose patterns? □ no □ YES

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

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

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

Does patient carry rescue glucose with him/her? □ 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:

□ glucagon □ alcohol pads □ sharps box □ medic alert application □ log book

□ insulin brands_____

□ insulin pump supplies, specifically:_____

_____

□ glucose test strip brand_____

□ insulin syringes, specifically size:_____

□ ketone strip brand_____

□ lancet brand_____

□ 504 plan

□ diabetes camp form (please provide form)

□ TSA letter for air travel

If the patient needs other prescriptions/supplies, which?_____

_____