

**PEDIATRIC ENDOCRINE & DIABETES SPECIALISTS
PEDIATRIC ENDOCRINOLOGY
INITIAL CONSULT**

all

Parent/Patient: Please complete the first 2 pages

Patient Name _____ Address _____ City _____ State/Zip _____ Home Phone # _____ Cellular Phone # _____ Fathers' Name _____ Mother's Name _____	Date seen _____ DOB _____ Referring Physician _____ Address _____ MD Phone # _____ Father Occupation/Phone # _____ Mother Occupation/Phone # _____
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Why are you bringing your child?

- | | | |
|---|---|---|
| <input type="checkbox"/> Diabetes | <input checked="" type="checkbox"/> Poor growth | <input type="checkbox"/> Early sexual development |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Excessive growth | <input type="checkbox"/> Late sexual development |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Lead toxicity | <input type="checkbox"/> Calcium problems |
| <input type="checkbox"/> Brain Tumor | <input type="checkbox"/> Radiation exposure | <input type="checkbox"/> Abnormal thyroid tests |
| <input type="checkbox"/> Other (describe) _____ | | |
- Duration of problem _____

FAMILY HISTORY

	Age	Height	Weight	Timing of puberty (early, late, average)	Health & Comments
Father					
Mother					
Mother's mother					
Mother's father					
Father's mother					
Father's father					
Siblings					
Siblings					
Siblings					
Siblings					

Please check off the illnesses which relatives (including aunts, uncles, cousins, and grandparents) have:

Illness	Relative(s) & Details
<input type="checkbox"/> Diabetes	
<input type="checkbox"/> Thyroid Disease	
<input type="checkbox"/> Early Puberty	
<input type="checkbox"/> Late Puberty	
<input type="checkbox"/> Short Stature	
<input type="checkbox"/> Other hormonal diseases	
<input type="checkbox"/> High blood pressure	
<input type="checkbox"/> Bone Disease	
<input type="checkbox"/> Liver Disease	
<input type="checkbox"/> Cancer	
<input type="checkbox"/> Kidney Disease	
<input type="checkbox"/> Lung Disease	
<input type="checkbox"/> Heart Disease (< 55 years)	
<input type="checkbox"/> Other	

PATIENT NAME: _____

DATE: _____

BIRTH HISTORY

Please answer the following:

Medications taken during pregnancy _____
 If pregnancy complicated, please explain _____
 Full term Yes No Premature _____ weeks
 Delivery Vaginal _____ Cesarean Reason for C-section _____
 Birth weight/length _____ / _____ Any problems in nursery (jaundice, cyanosis)? Yes No
 If yes, please explain _____

DEVELOPMENTAL & SOCIAL HISTORY

Please answer when your child met developmental milestones and describe issues with school and behavior

Roll over On time Late Grade in school _____
 Sit up On time Late Marks in school _____
 Walk alone On time Late Problems in school _____
 Talk (2 words) On time Late _____
 Toilet train On time Late _____

Diet problems _____
 Sleep problems _____
 Social problems _____
 Behavioral problems _____
 Personality _____

MEDICAL HISTORY

Please fill in the following with dates and places with description:

Hospitalizations _____
 Surgery _____
 Allergies _____
 Current medications _____
 Past medications taken for more than 2 weeks _____
 Immunizations _____
 Have menstrual periods begun No Yes Age of onset _____ Cycles regular No Yes
 Last menstrual period began _____ days ago Menstruation concerns _____
 Any other health problems _____

REVIEW OF SYSTEMS

Please check yes or no for the following symptoms your child may be experiencing

→		Y	N		Y	N		Y	N	COMMENTS
Constitutional	Weight loss/gain			Fever			Fatigue			<div style="border: 1px solid black; padding: 5px; width: fit-content; margin-left: auto;"> ROS 99242 = 1 99243 = 2-9 99244 = ≥ 10 99245 = > 10 </div>
Eyes	Eye swelling			Double vision						
ENT	Ear Infection			Throat pain			Nosebleeds			
CV	Chest pain			Palpitations			Murmur			
Resp	Shortness of breath			Cough			Wheezing			
GI	Nausea/vomiting			Diarrhea			Abdominal pain			
GU	Urinating frequently			Allergy to meds						
Endocrine	Urinating in large amts			Excessive thirst			Other			
Skin	Rash			Lesions						
Musculoskeletal	Joint swelling			Joint pain						
Neuro	Headache			Fainting						
Psych	Difficulty sleeping			Depression						
Hem/Lymph	Bruising/bleeding			Anemia			Swollen glands			
Allergic/Immun	Frequent infection			Allergy to meds						

Parent/Patient Signature: _____

Date completed: _____