

**Medical Group**

**Pediatric Endocrinology and Diabetes**

**New patient Form**

Patient Information		
Patient's Name:		Today's Date:
Patient's age:	Patient's Date of Birth:	Patient's gender:
Relationship of person completing form:		
Age when concern started:	Referred by: [ ] Physician Name:	
Any tests, labs or x-rays completed related to today's visit? [ ]yes [ ]No		
Where were they performed?		When?
Has the child been seen by an endocrinologist previously? [ ]No [ ]Yes, When?		
Did your child's primary physician recommend this visit? [ ] Yes [ ] No		
Main reason for visit today?		
Parent Guardian Information		
Parent One Name:		Best contact number:
Parent Two Name:		Best contact number:
Home Address:		Home Phone:
City:		Zip Code:
Parent One Occupation:		
Parent Two Occupation:		
Emergency Contact Name:		Best contact number:
Relationship to child:		
Custody		
Parents are: [ ]Married [ ]Separated [ ]Divorced		
If divorced or separated, who has legal custody?		
Are any of the parents restricted (must provide legal paperwork) from being included or provided medical information about the patient? [ ] Yes [ ]No		
Pediatrician Information		
Physician's Name:		Phone:
Address:	City:	Zip code:
Fax if known:		

<b>School Information</b>	
<input type="checkbox"/> Not applicable, go to next section	Grade level:
Any learning disabilities <input type="checkbox"/> No <input type="checkbox"/> Yes, please explain: _____	Therapies child is receiving (check all that apply) <input type="checkbox"/> OT <input type="checkbox"/> PT <input type="checkbox"/> Speech therapy <input type="checkbox"/> Tutoring in:
Performance: <input type="checkbox"/> As expected <input type="checkbox"/> Below expected <input type="checkbox"/> Above expected	
<b>Birth Information</b>	
Were there any concerns during pregnancy? <input type="checkbox"/> No <input type="checkbox"/> Yes, please list below	
Full term <input type="checkbox"/> Yes <input type="checkbox"/> No, # of weeks _____	<input type="checkbox"/> Child adopted, history not known
Birth weight: _____ lbs. _____ oz.	Birth length: _____ inches
Any problems during delivery? <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, explain:	
Did child require breathing assistance at birth? <input type="checkbox"/> No <input type="checkbox"/> Yes	
Did the child go to the ICU? <input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, how many days and reason: _____ Days for:
<input type="checkbox"/> Breast milk <input type="checkbox"/> Formula <input type="checkbox"/> Special formula	Diet/weight concerns? <input type="checkbox"/> No <input type="checkbox"/> Yes
Did your child have any developmental delays? <input type="checkbox"/> No <input type="checkbox"/> Yes, please list:	
<b>Medical History</b>	
Current medications, vitamins or supplements child takes?	
Name:	Dose:
Name:	Dose:
Name:	Dose:
Name:	Dose:
Does the child have any drug allergies? <input type="checkbox"/> No <input type="checkbox"/> Yes	
Drug name:	Reaction:
Drug name:	Reaction:
Drug name:	Reaction:
<b>Hospitalizations / Emergency Room Visits</b>	
Has your child been hospitalized overnight? <input type="checkbox"/> No <input type="checkbox"/> Yes	
Date of stay? _____	# of Nights _____ Reason: _____
Date of stay? _____	# of Nights _____ Reason: _____
<b>Surgeries <input type="checkbox"/> No <input type="checkbox"/> Yes list below:</b>	
Year	Type of Surgery

<b>Medical History</b>			
Does your Child show signs of Sexual Development (Puberty)? [ <input type="checkbox"/> ]Yes [ <input type="checkbox"/> ]No			
If yes, at what age did you first notice the following in your child? (List age)			
Body odor ____years old	Underarm Hair ____years old	Acne ____years old	
Facial hair ____years old	Pubic hair ____years old		
<b>Female Patients</b>			
Breast budding/tenderness ____years old	First bleeding period ____years old		
<b>Male Patients</b>			
Growth of penis or testicles ____years old	Voice deepening ____years old		
<b>All Patients - Other Medical Concerns</b>			
Does your child have concerns with any of the following: (provide details below)			
Dark or pale skin spots or birthmarks?	[ <input type="checkbox"/> ]Yes [ <input type="checkbox"/> ]No	Details:	
Headaches, seizures, or loss of consciousness?	[ <input type="checkbox"/> ]Yes [ <input type="checkbox"/> ]No	Details:	
Broken bones or head injuries?	[ <input type="checkbox"/> ]Yes [ <input type="checkbox"/> ]No	Details:	
Vision concerns?	[ <input type="checkbox"/> ]Yes [ <input type="checkbox"/> ]No	Details:	
Hearing loss or ear infections?	[ <input type="checkbox"/> ]Yes [ <input type="checkbox"/> ]No	Details:	
Loss/heightened sense of smell?	[ <input type="checkbox"/> ]Yes [ <input type="checkbox"/> ]No	Details:	
Eating (swallowing or appetite) concerns?	[ <input type="checkbox"/> ]Yes [ <input type="checkbox"/> ]No	Details:	
Heart or blood pressure concerns?	[ <input type="checkbox"/> ]Yes [ <input type="checkbox"/> ]No	Details:	
Asthma? If known list severity level in details.	[ <input type="checkbox"/> ]Yes [ <input type="checkbox"/> ]No	Details:	
Other medical condition/s:	Details:		
<b>Relevant Family History</b>			
[ <input type="checkbox"/> ]Section not applicable – family history is not known for child.			
	<b>Age</b>	<b>Height</b>	<b>Puberty</b>
Father			Reached final height at ____yrs
Mother			First Period at ____ yrs
Sibling:			
Sibling:			
Sibling:			

Does anyone on either side of the family have a medical problem with anything listed below?	Choose (yes or no)	List relationship (i.e., brother, sister, mother, father, grandparent, cousin)
Diabetes	[ ]Yes [ ]No	
Thyroid or goiter	[ ]Yes [ ]No	
Short stature	[ ]Yes [ ]No	
Late or early puberty	[ ]Yes [ ]No	
Adrenal hormone problem	[ ]Yes [ ]No	
Unable to have children	[ ]Yes [ ]No	
High or low calcium problems	[ ]Yes [ ]No	
Child died early	[ ]Yes [ ]No	
High Cholesterol	[ ]Yes [ ]No	
High blood pressure	[ ]Yes [ ]No	
Tumor in childhood?	[ ]Yes [ ]No	
Heart attack or stroke before 55 years of age	[ ]Yes [ ]No	
<b>Other Information</b>		
Please list any other information that you feel is important for us to know:		

IF YOUR CHILD HAS A PROBLEM WITH HEIGHT OR WEIGHT, THEN ***BRING ALL GROWTH RECORDS*** FROM HOME, SCHOOL, AND CHILD'S PHYSICIAN

**Return this form to:**

Pediatric Endocrinology  
9977 Woods Drive, Suite 300  
Skokie, IL 60077  
Phone: 847.663.8508  
**Fax: 847.663.8515**

**Please note:** appointments cancelled and/or rescheduled less than 24 business hours in advance will result in a **\$100.00** charge.