NH Pediatric Endocrinology New Patient History

Date: _____

General Information

Patient's Name: _____ Age: _____ DOB: _____

Reason for today's visit: _____

When did this problem start? _____ Any labs or X-Rays for this problem? _____

Has child been seen by an endocrinologist before? ☐ Yes ☐ No If yes, when, where, why? _____

Birth History

Birth Weight: _____ Birth Length: _____ ☐ Vaginal Delivery ☐ C-Section - Reason: _____

☐ Full Term ☐ Born Early ☐ Born Late How many weeks? _____ Problems with pregnancy? ☐ Yes ☐ No List:

Problems with delivery? ☐ Yes ☐ No Explain: _____

Did child go to the NICU at birth? ☐ Yes ☐ No Explain: _____

Medical History

Any hospitalizations or ED visits? ☐ Yes ☐ No List: _____

Any surgeries? ☐ Yes ☐ No List: _____

Any major or chronic medical problems – such as asthma or ADHD? ☐ Yes ☐ No Explain: _____

Developmental History

Any development problems? ☐ Yes ☐ No Explain: _____

Diet History

Diet/Weight concerns: _____

Exercise History

On average, how many minutes of physical activity does child get per day? _____

What types of activities? _____

On average, how many hours spent on TV/phone/video games/computer/tablet per day? _____

Social Information

Parents are: ☐ Married ☐ Separated ☐ Divorced ☐ Never Married

Who lives at home with the child? _____

School: _____ Grade: _____ School Performance: _____

After school activities: _____

Mother's age at first menstrual period? _____ Father's puberty early or late? ☐ Yes ☐ No

Family History: ☐ Adopted

Relationship to patient	Name	Age	Height	Health Problems
Mom				
Mom's mother				
Mom's father				
Dad				
Dad's mother				
Dad's father				
Sibling (brother/sister)				
Sibling (brother/sister)				
Sibling (brother/sister)				

Please list family members with the following diseases:

Disease	Relationship to patient
Adrenal disease	
Calcium problems/Osteoporosis	
Diabetes	
Cholesterol problems	
Heart attack or stroke before age 50	
High blood pressure	
Kidney problems	
Thyroid disease	
Cancer/Tumors (list type)	
Stomach or colon problems	
Vitiligo	
Rheumatoid arthritis	
Celiac disease	
PCOS/Irregular periods	
Early or late puberty	

Medication Information

List of child's medications in detail **or** attach list: _____

Any herbal/natural supplements? ☐ Yes ☐ No Biotin? ☐ Yes ☐ No Vitamin D? ☐ Yes ☐ No

Any medication allergies? ☐ Yes ☐ No List: _____

Other allergies/intolerances? _____

Preferred pharmacy? _____

Review of Systems

Please check if your child has a history of any of the following:

	Yes	No		Yes	No		Yes	No
General	☐	☐	**Respiratory**	☐	☐	**Skin**	☐	☐
Poor weight gain	☐	☐	Wheezing	☐	☐	Acne	☐	☐
Recent weight loss	☐	☐	Coughing	☐	☐	Infections	☐	☐
Frequent fevers	☐	☐	Chest pain	☐	☐	Dryness/Oiliness	☐	☐
Fatigue (tiredness)	☐	☐	Difficulty catching breath	☐	☐	Darkening of skin	☐	☐
Paleness	☐	☐	Fast breathing	☐	☐	Unusual hair growth	☐	☐
Weight gain	☐	☐				Describe:		
			Heart/Blood vessels			Stretch marks	☐	☐
Endocrine			Problems with heart	☐	☐	Birth marks	☐	☐
Heat or cold sensitivity	☐	☐	High blood pressure	☐	☐	Describe:		
Nausea or vomiting	☐	☐	Heart murmur	☐	☐			
Excessive sweating	☐	☐	Blue spells	☐	☐			
Nighttime sweating	☐	☐	Dizziness	☐	☐	**Blood/Lymph**		
Diabetes/high blood sugar	☐	☐	Swelling of hands/feet	☐	☐	Anemia	☐	☐
Low blood sugar	☐	☐	Palpitations	☐	☐	Easy bruising or bleeding	☐	☐
Excessive thirst	☐	☐				Enlarged lymph nodes	☐	☐
Excessive hunger	☐	☐	**Digestive**					
Excessive urination	☐	☐	Coughing/gagging with eating	☐	☐	**Muscles/Bone**		
Salt craving	☐	☐	Diarrhea/frequent stools	☐	☐	Muscle weakness	☐	☐
Bedwetting/daytime accidents	☐	☐	Constipation	☐	☐	Joint problems	☐	☐
Slow or rapid growth	☐	☐	Abdominal pain	☐	☐	Limp	☐	☐
Early puberty	☐	☐	Vomiting	☐	☐	Bone pain	☐	☐
Late puberty	☐	☐				Broken bones	☐	☐
Breast changes	☐	☐	**Genitourinary**			Describe:		
			Frequent urination	☐	☐			
Eyes			Yeast infections	☐	☐	**Neurologic**		
Glasses/contact lenses	☐	☐	Pain or burning on urination	☐	☐	Headaches	☐	☐
Double vision	☐	☐	For girls:			Seizure	☐	☐
Eye pain	☐	☐	First menstrual period:			Paralysis	☐	☐
Eye redness/dry eyes	☐	☐	Last menstrual period:			Weakness	☐	☐
Double vision	☐	☐	Problems with menstruation:	☐	☐	Head Trauma	☐	☐
						Tremors	☐	☐
Ears/Nose/Throat			**Allergy/Immune System**			Speech problem	☐	☐
Ear problems	☐	☐	Frequent infections	☐	☐			
Hearing loss	☐	☐	Watery eyes	☐	☐	**Psychiatric/Behavioral**		
Sinus trouble	☐	☐	Nasal congestion	☐	☐	Mood swings	☐	☐
Snoring	☐	☐	Sneezing	☐	☐	Temper outbursts	☐	☐
Inability to smell	☐	☐	Runny nose	☐	☐	Nervousness	☐	☐
Nosebleeds	☐	☐				Trouble sleeping	☐	☐
Change in voice	☐	☐				Depression	☐	☐
Trouble swallowing	☐	☐						

If limited English proficient or hearing impaired, offer interpreter at no additional cost:

☐ Interpreter Accepted _____ ☐ Interpreter Refused

(Name/Number of Person/Services Chosen/Used)

Patient Name:_____

DOB:_____

(or use patient label)
Name / MR # / Label