The Pediatric Endocrine & Diabetes Clinic, PC

New Patient Information Sheet

Patient Label

Thank you for choosing us for your care provider.

CHILD'S NAME:_____

PARENTS' NAMES:_____

BIRTH HISTORY

Birth weight _____

Mom ill during pregnancy	☐ Yes	☐ No
Normal delivery	☐ Yes	☐ No
Was the baby born on time	☐ Yes	☐ No
Did the baby have any problems	☐ Yes	☐ No
Puffy hands	☐ Yes	☐ No
Jaundice	☐ Yes	☐ No

PAST HISTORY

1. **Does your child have a history of**:

Asthma	☐ Yes	☐ No
Allergies	☐ Yes	☐ No
Seizures	☐ Yes	☐ No
Ear infections	☐ Yes	☐ No

2. **Hospitalizations** ☐ Yes ☐No
   When _____
   Why _____

3. **Please List Surgeries:**

FAMILY HISTORY

Diabetes	☐ Yes	☐ No
Thyroid problems	☐ Yes	☐ No
High Cholesterol	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
Lupus/Arthritis	☐ Yes	☐ No

Other:

_____

_____

Mom's Ethnicity _____ Age____ Height____
Dad's Ethnicity _____ Age____ Height____

REVIEW OF SYSTEMS: Has your child had?

Weight loss, weight gain	☐ Yes	☐ No
Headaches	☐ Yes	☐ No
Drinking a lot	☐ Yes	☐ No
Eating a lot	☐ Yes	☐ No
Vision, Hearing problems	☐ Yes	☐ No
Frequent infections	☐ Yes	☐ No
Feeling very hot or cold	☐ Yes	☐ No
Cough	☐ Yes	☐ No
Chest pain	☐ Yes	☐ No
Heart flutters	☐ Yes	☐ No
Any Pain	☐ Yes	☐ No
Vomiting	☐ Yes	☐ No
Diarrhea	☐ Yes	☐ No
Constipation	☐ Yes	☐ No
Rashes	☐ Yes	☐ No
Dry skin	☐ Yes	☐ No
Stretch Marks	☐ Yes	☐ No
Abnormal hair growth	☐ Yes	☐ No
Abnormal body odor	☐ Yes	☐ No
Development of puberty	☐ Yes	☐ No
Numbness of hands/feet	☐ Yes	☐ No
Weakness	☐ Yes	☐ No
Trouble sleeping	☐ Yes	☐ No
Behavioral changes	☐ Yes	☐ No
Hair Loss	☐ Yes	☐ No

DEVELOPMENT

Age walked _____
Grade _____ Hobbies/Sports _____
Saying words by 18 months ☐ Yes ☐ No