Banner Health®

ESTABLISHED MEDICAL HISTORY - PEDIATRIC DIABETES

Patient Name: _____ **Date of Birth:** _____ **Gender: M / F**

Person filling out form and relationship to patient: _____

Please provide as much detail as you are able so that we can give you the safest and best care possible.

Preferred Pharmacy (name and location): _____

What is the most important concern we can address at this visit? _____

_____

ALLERGIES

❑ **No known allergies** List any allergies and intolerances to **medications, food or the environment.**

Allergy:	**Reaction:**

MEDICATIONS

❑ **No Medications**

List any medications you are taking, with dose and how often. List any Vitamins, Supplements and Over the Counter Medicines.

Medication Name:	**Dose:**	**How often?**

PATIENT MEDICAL HISTORY

Since your last clinic visit has your child:

Had a serious illness or been hospitalized? ❑ Yes ❑ No If yes, explain: _____

Been seen in the emergency department? ❑ Yes ❑ No If yes, explain: _____

Had surgery? ❑ Yes ❑ No If yes, explain: _____

FAMILY HISTORY

Have any new medical conditions been diagnosed in the family since the last visit? ❑ Yes ❑ No If yes, explain: _____

_____

_____

_____

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SOCIAL HISTORY

Patient lives with: ❑ Mother ❑ Father ❑ Siblings ❑ Grandparents ❑ Step-Parents ❑ Foster Parents ❑ Adoptive Parents

Any significant stress in the household? _____

Current grade (last grade completed in school if out of session): _____ Not applicable _____

School performance: ❑ Below average ❑ Average ❑ Above average

Extracurricular activities/sports: _____

Average number of school days missed/year? ❑ less than 5 days ❑ 5-10 days ❑ 11-20 days ❑ more than 20 days

MENSTRUAL HISTORY
(Females Only)

Has your child ever had a menstrual period? ❑ Yes ❑ No If yes, age of onset: _____ Date of last period: _____

Are they regular (every month)? ❑ Yes ❑ No If no, explain: _____

Length of period? ❑ less than 5 days ❑ 5-7 days ❑ more than 7 days

Character of bleeding: ❑ Light ❑ Moderate

REVIEW OF SYSTEMS

GENERAL			GASTROINTESTINAL			IMMUNOLOGICAL		
Unusually fatigued or tired	**Yes**	**No**	Chronic vomiting	**Yes**	**No**	Frequent infections	**Yes**	**No**
Weight gain	**Yes**	**No**	Constipation	**Yes**	**No**	**SKIN**		
Weight loss	**Yes**	**No**	Diarrhea	**Yes**	**No**	Abnormal hair growth	**Yes**	**No**
ENT			**GENITOURINARY**			Hair loss	**Yes**	**No**
Hearing problems	**Yes**	**No**	Urinating a lot	**Yes**	**No**	Rash	**Yes**	**No**
Vision problems	**Yes**	**No**	**ENDOCRINE**			**NEUROLOGICAL**		
RESPIRATORY			Abnormal body odor	**Yes**	**No**	Dizzy/light headed	**Yes**	**No**
Cough	**Yes**	**No**	Drinks a lot	**Yes**	**No**	Frequent or recurring headaches	**Yes**	**No**
Nighttime snoring	**Yes**	**No**	Early puberty	**Yes**	**No**	Seizures	**Yes**	**No**
Shortness of breath	**Yes**	**No**	Eating a lot	**Yes**	**No**	Dizzy/light headed	**Yes**	**No**
CARDIOVASCULAR			Feeling very hot or cold	**Yes**	**No**	**PSYCHIATRIC**		
Chest pain	**Yes**	**No**	Abnormal body odor	**Yes**	**No**	Feeling sadness/helplessness	**Yes**	**No**
Irregular heart beat	**Yes**	**No**	**MUSCULOSKELETAL**			Trouble sleeping	**Yes**	**No**
Palpitations	**Yes**	**No**	Back pain	**Yes**	**No**			
			Joint pain	**Yes**	**No**			
			Muscle pain	**Yes**	**No**			

If yes, please explain: _____

_____

_____

_____

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(10/2015)

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BLOOD GLUCOSE MONITORING

Monitor used: _____

Who checks blood sugars (check all that apply): ❑ Child ❑ Parent ❑ Grandparent ❑ Other: _____

On average, how many times a day are blood sugars checked: ❑ 1 ❑ 2 ❑ 3 ❑ 4 or more

Are blood sugars checked at night? ❑ Yes ❑ No If yes, most readings are ❑ >100 ❑ <100

INSULIN TREATMENT/INJECTIONS

Who gives the insulin shots? ❑ Child ❑ Siblings ❑ Parent ❑ Grandparent ❑ Other: _____

Where are the shots given? ❑ Buttocks ❑ Leg ❑ Stomach ❑ Arms ❑ Other: _____

Any lumps at injections sites? ❑ Yes ❑ No If yes, explain: _____

Leakage, bleeding, discomfort when insulin injected? ❑ Yes ❑ No If yes, explain: _____

Estimated number of missed injections: ❑ None ❑ 1-2/day ❑ 1-2/week ❑ 1-2/month

URINE KETONE TESTING

When do you check for ketones? ❑ high blood sugars ❑ Illness ❑ Other: _____

Has your child had ketones since your last visit? ❑ Yes ❑ No If yes, explain: _____

HYPERGLYCEMIA (HIGH BLOOD SUGARS) SIGNS AND SYMPTOMS/TREATMENT

Has your child experienced: ❑ Increased thirst ❑ Increased urination ❑ Urinating during the night ❑ Bedwetting

What time are your child's blood sugars highest? ❑ Breakfast ❑ Mid-morning ❑ Lunch ❑ Mid-afternoon ❑ Dinner ❑ Bedtime ❑ During sleep

In general, how do you treat high blood sugars? ❑ Don't use extra insulin ❑ Use extra insulin

HYPOGLYCEMIA (LOW BLOOD SUGARS) SIGNS AND SYMPTOMS/TREATMENT

If your child's blood sugar is low (<80) when does it mostly occur? ❑ AM Meal ❑ Mid-morning ❑ Lunch ❑ Mid-afternoon ❑ PM meal ❑ Bedtime ❑ During sleep

What is the blood sugar range at which your child has symptoms of low blood sugar? ❑ <50 mg/dl ❑ <60 mg/dl ❑ <70 mg/dl ❑ <80 mg/dl ❑ <90 mg/dl ❑ <100 mg/dl ❑ Other: _____

Which do you use most commonly to treat low blood sugar? ❑ Candy ❑ Chocolate ❑ Soda/juice ❑ Glucose gel/tabs ❑ Cake icing ❑ Other: _____

Do you have a glucagon kit at home? ❑ Yes ❑ No If yes, expiration date: _____

Has your child required glucagon since last visit? ❑ Yes ❑ No

VISION

Does your child complain of blurred vision? ❑ Yes ❑ No

Does your child wear glasses/contacts? ❑ Yes ❑ No

Has your child seen an eye doctor within the past year? ❑ Yes ❑ No

Are there any smokers in the home? ❑ Yes ❑ No

DIABETES EDUCATION

I would like more information on the following:

❑ Advance diabetes treatment ❑ Exercise and diabetes ❑ Sexual health/pregnancy ❑ Vaccine recommendations

❑ Blood sugar monitoring ❑ Heart healthy eating ❑ Sick day management ❑ Weight loss

❑ Carbohydrate counting ❑ Insulin pumps ❑ Urine ketone testing

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