Banner Health®

NEW PATIENT MEDICAL HISTORY - PEDIATRIC ENDOCRINOLOGY

Patient Name: ______________________________ **Date of Birth:** ____________ **Gender: M / F**

Person filling out form and relationship to patient: ______________________________

Parent Occupation: ______________________________

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): ______________________________

Primary Care Provider

Name: ______________________________ Phone #: ______________

Address: ______________________________ Fax #: ______________

Does your child see any other specialists? ______________________________

Reason for 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

List any current or past medical conditions (please place checkmark by any current problems).

❑ ______________________________

❑ ______________________________

❑ ______________________________

❑ ______________________________

❑ ______________________________

51000024 Patient Intake

5100-0024
(10/2015)

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SURGERIES AND/OR HOSPITALIZATIONS

Has your child had any surgeries or has been hospitalized? (provide dates and reason below)?

Date:	Reason:	Date:	Reason:

FAMILY HISTORY

List health conditions for each family member.

	Alive	Deceased	Age of Death	Health Condition(s)
Father				
Mother				
Paternal Grandmother				
Paternal Grandfather				
Maternal Grandmother				
Maternal Grandfather				
Brother				
Sister				

Height of Mother: ____________________ Height of Father: ____________________

SOCIAL HISTORY

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

Name: ____________________ Name: ____________________ Name: ____________________

Name: ____________________ Name: ____________________ Name: ____________________

Child attends school: ______________________________ Grade: ____________ ❑ Not applicable

Extracurricular activities/sports: ______________________________

Father's occupation: ______________________________

Mother's occupation: ______________________________

MATERNAL AND BIRTH HISTORY

Maternal

Maternal Age: ______ Prenatal Care: ❑ Yes ❑ No ❑ Full Term ❑ Premature

weeks gestation (how for along were you?): ____________________

Complications during pregnancy? ❑ Yes ❑ No If yes, please explain ______________________________

Type of delivery: ❑ Normal Vaginal ❑ C-Section ❑ Repeat C-Section ❑ Emergent C-Section (Reason) ____________

BIRTH HISTORY

(Complete if under 5 years old)

Birth Weight: ______ lbs. ______ oz. Type of delivery: ❑ Vaginal ❑ C-Section

Gestational age at birth: ____________ weeks

Any complications during pregnancy? ❑ Yes ❑ No If yes, explain: ______________________________

Any complications at birth? If yes, explain: ______________________________

Birth Weight: _______ lbs. ______ oz. Length: __________ Head Circumference: _______ inches Time of Birth: ____________

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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 ❑ Heavy

ETHNIC BACKGROUND

Many medical conditions are unique to ethnicity. Help us understand your child/teen's ancestry. Choose all that apply.

❑ American Indian, Native American ❑ Alaska Native ❑ Apache ❑ Cocopah ❑ Havasupai ❑ Hopi ❑ Hualapai, Mojave

❑ Navajo ❑ Pascua ❑ Paiute ❑ Quechan ❑ Tohone O'odham ❑ Yavapai ❑ Other: ____________________________

❑ Asian: original peoples of the Far East, Southeast Asia, or the South Asian Subcontinent including, for example, Cambodia, China, India, Japan, Thailand, Malaysia, Pakistan, Philippines

❑ Black or African American having origins in any of the black racial groups of Africa.

❑ Hispanic or Latino. A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture origin.

❑ Native Hawaiian & Other Pacific Islander: having origins in any of the original people of Hawaii, Guam, Samoa, or other Pacific Islands.

❑ White: any of the original peoples of Europe, the Middle Ease, or North Africa.

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	**MUSCULOSKELETAL**			Feeling sadness/helplessness	Yes	No
Irregular heart beat	Yes	No	Back pain	Yes	No	Trouble sleeping	Yes	No
Palpitations	Yes	No	Joint pain	Yes	No			
			Muscle pain	Yes	No			

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