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? ______________________________

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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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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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