NEW PATIENT MEDICAL HISTORY - PEDIATRIC ENDOCRINOLOGY

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

Gender Identity (Optional) ____________________

Name of Person filling out form and relationship to patient: ____________________

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

Preferred Pharmacy (name and location): ____________________

Primary Care Provider

Name: ____________________ Phone #: ____________

Does your child see any other specialists? If so, include specialty and reason: ____________________

____

Reason for today's visit here: ____________________

ALLERGIES

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

Allergy:	Reaction:

MEDICATIONS

❑ **No Medications**

List any medications your child is taking, with dose and how often. List all Prescriptions, Over-the-Counter Medications, Vitamins and Supplements.

Medication Name:	Dose:	How often?

PATIENT MEDICAL HISTORY

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

DO NOT RETAIN AS PART OF THE PERMANENT MEDICAL RECORD

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(08/2018)

Banner Health

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Patient Name: ______________________________ Date of Birth: ______________

SURGERIES AND/OR HOSPITALIZATIONS

❑ No Surgeries or Hospitalizations

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: ______________

Education: ❑ Public/Private school ❑ Online school ❑ Home-schooled: ________ Grade: _____ ❑ Not applicable

Extracurricular activities/sports: ______________________________

Father's occupation: ______________________________

Mother's occupation: ______________________________

MATERNAL AND BIRTH HISTORY

Mother's age at time of delivery: _____ Prenatal Care: ❑ Yes ❑ No ❑ Full Term ❑ Premature

weeks gestation (how far along were you?): ______________

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

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

Medications taken during pregnancy? ❑ Yes ❑ No If yes, include names: ______________________

Gestational Diabetes: ❑ Yes ❑ No

Any complications at birth? ❑ Yes ❑ No If yes, explain: ______________________

Birth Weight: _____ lbs. _____ oz. Length: ________ Head Circumference: _____ inches

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Patient Name: ______________________________ Date of Birth: ______________

MENSTRUAL HISTORY

(Females Only)

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

Are cycles 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 people 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 East, or North Africa.

REVIEW OF SYSTEMS

GENERAL			GASTROINTESTINAL			Seizures	Yes	No
Unusually fatigued or tired	Yes	No	Chronic vomiting	Yes	No	Fainting	Yes	No
Weight gain	Yes	No	Constipation	Yes	No	GENITOURINARY		
Weight loss	Yes	No	Diarrhea	Yes	No	Urinating a lot	Yes	No
ENT			ENDOCRINE			Pain with urination	Yes	No
Hearing problems	Yes	No	Abnormal body odor	Yes	No	PSYCHIATRIC		
Vision problems	Yes	No	Drinks a lot	Yes	No	Change in mood or behavior	Yes	No
RESPIRATORY			Early puberty	Yes	No	Trouble sleeping	Yes	No
Cough	Yes	No	Delayed Puberty	Yes	No	SKIN		
Nighttime snoring	Yes	No	Eating a lot	Yes	No	Abnormal hair growth	Yes	No
Shortness of breath	Yes	No	Feeling very hot	Yes	No	Hair loss	Yes	No
CARDIOVASCULAR			Feeling very cold	Yes	No	Rash	Yes	No
Chest pain	Yes	No	NEUROLOGICAL			Excessively dry skin	Yes	No
Irregular heart beat	Yes	No	Dizzy/light headed	Yes	No	IMMUNOLOGICAL		
Palpitations	Yes	No	Frequent or recurring headaches	Yes	No	Frequent infections	Yes	No

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