Pediatric Endocrinology Established Patient Health History

Name: _____ **DOB:** _____

Please Circle Yes or No:

- Does patient need any prescription refills? YES NO
- Does patient currently have school orders? YES NO
- Has the patient had any lab work or imaging performed recently that would impact this visit?

  YES NO
  - If YES – please indicate where labs or imaging were performed:
    - _____

Please write down all current medications that need a refill (including test strips, syringes, etc.):

- _____
- _____
- _____
- _____
- _____
- _____