Pediatric Endocrinology New Diabetes Patient Health History

Name: _____ **DOB:** _____

List two (2) main concerns for today's visit:

1. _____
2. _____

Patient's past medical history:

- Has the child ever had surgery? If "yes", please explain: _____

  _____

  _____
- Is the child currently taking medications? If "yes", please list: _____

  _____

  _____
- Does the child have any allergies? If "yes", please list: _____

  _____

  _____

Family medical history:

What is the father's height? _____ What is the mother's height? _____

Has any* family member had any of the following? If "yes", please circle:
*(please only include history for biological mother, father, grandparents, aunts, uncles, brothers or sisters)

Thyroid disorder	High lipids (triglycerides,	Other autoimmune conditions
Type 1 diabetes	cholesterol)	(SLE, rheumatoid arthritis,
Type 2 diabetes	Celiac disease	etc.)
Heart disease	Adrenal insufficiency	Any other health problem

Date of last eye exam:	**Circle one:** Was your eye exam NORMAL or ABNORMAL
Circle one: Humalog, Novolog, Admelog, or Apidra	**For injections only (skip if on insulin pump)** **Mealtime insulin:** ___ units for every ___ grams of carbohydrates **Correction dose:** ___ units for every ___ points BS is above ___
Circle one: Lantus, Levemir, Basaglar, Toujeo, Tresiba	**For injections only (skip if on insulin pump)** ___ units at ___ AM/PM **Circle one:** Pens or Vials
What glucose meter do you use? _____	

Please circle if you need refill soon of any of the following medications:

- Glucagon
- Zofran (anti-nausea pill)
- Blood ketones strips
- Urine ketones strips
- Ketone meter
- Insulin syringes to administer mimi glucagon
- Back-up long acting insulin (*if on insulin pump only*)
- Other: _____

Other questions:

1. How often do you give insulin before a meal or snack? _____ % of the time.
2. Are you giving correction doses outside of mealtimes? YES or NO
3. How often in the last month have you woken to treat a low or blood sugar? _____
4. Where are you giving injections? ABDOMEN, HIPS, BUTTOCKS, ARMS, THIGHS, OTHER
5. Have you had any lab work or imaging performed recently that would impact this visit?
    a. YES or NO
        i. If yes – where were they performed: _____

Female only: Date of last menstrual period:_____

Please circle any symptoms the patient is experiencing:

Fatigue	Loss of appetite	Palpitation
Constipation	Amenorrhea (late/no periods,	Shortness of breath
Vitiligo (loss of skin color)	spotting)	Coughing wheezing
Hyperpigmentation	Heartburn	Abdominal pain
Easy bruising	Nausea	Headaches/migranes
Excelssively dry skin	Vomiting	Numbness
Hair loss	Weight loss	Tingling
Rash	Weight gain	Tremors
Itchy skin	Increased hunger	Dizziness
Itchy eyes	Increased thurst	Back pain
Red eyes	Increased urination	Joint pain
Runny nose	Urination at night	Joint swelling
Congestion	Painful urination	Muscle cramping
Fever	Blood in stool	Memory loss
Ear pain	Sensitivity to tempearatures	Acne
Sore throat	(hot/cold)	Hives
Swelling	Blurry vision	Depression
Insomnia/sleep disturbance	Decreased vision	Anxiety
Night sweats	Chest pain	High stress
Diarrhea	Easy bruising	

Generalized Anxiety Disorder (GAD) Screening

Please circle only one answer for each question.

KEY: Not at all – 0, several days = 1, More than half the days = 2, Nearly everyday = 3

I am…

• Feeling nervous, anxious, or on edge	0	1	2	3
• Not able to stop or control worrying	0	1	2	3
• Worrying too much about different things	0	1	2	3
• Having trouble relaxing	0	1	2	3
• So restless that it is hard to sit still	0	1	2	3
• Easily annoyed or irritable	0	1	2	3
• Feeling afraid as if something awful might happen	0	1	2	3

TOTAL Score: (5 = mild; 10 = moderate; 15 = severe)