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Pediatric Endocrinology New 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
Type 1 diabetes
Type 2 diabetes
Heart disease

High lipids (triglycerides, cholesterol)
Celiac disease
Adrenal insufficiency

Other autoimmune conditions (SLE, rheumatoid arthritis, etc.)
Any other health problem

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Please circle any symptoms the patient is experiencing:

Fatigue
Constipation
Vitiligo (loss of skin color)
Hyperpigmentation
Easy bruising
Excelssively dry skin
Hair loss
Rash
Itchy skin
Itchy eyes
Red eyes
Runny nose
Congestion
Fever
Ear pain
Sore throat
Swelling
Insomnia/sleep disturbance
Night sweats
Diarrhea

Loss of appetite
Amenorrhea (late/no periods, spotting)
Heartburn
Nausea
Vomiting
Weight loss
Weight gain
Increased hunger
Increased thurst
Increased urination
Urination at night
Painful urination
Blood in stool
Sensitivity to tempearatures (hot/cold)
Blurry vision
Decreased vision
Chest pain
Easy bruising

Palpitation
Shortness of breath
Coughing wheezing
Abdominal pain
Headaches/migranes
Numbness
Tingling
Tremors
Dizziness
Back pain
Joint pain
Joint swelling
Muscle cramping
Memory loss
Acne
Hives
Depression
Anxiety
High stress