THE CLINICAL PRACTICE OF WESTERN MICHIGAN UNIVERSITY
HOMER STRYKER M.D. SCHOOL OF MEDICINE

# PEDIATRIC ENDOCRINOLOGY NEW PATIENT EVALUATION FORM

Please complete the following as best as you can prior to the visit. Please bring this form with you to your first visit.

## GENERAL INFORMATION

| | |
|---|---|
| Name of Patient: | Patient's age: Date of Birth: |
| Person completing this form: | Relation to patient: |
| Today's date: | |
| Has this patient been seen by an endocrinologist before? ☐No ☐ Yes<br>If yes: where, when, why? | |

**PHARMACY:** _____ **SPECIALITY PHARMACY:** _____
Do you need 90-day prescriptions? _____

**Please share why you are being seen today?** _____
_____

## BIRTH HISTORY

| | | | |
|---|---|---|---|
| Birth Weight: | Birth Length: | ☐ Vaginal deliver | ☐ C-section – why? |
| Full term/born early/ born late (circle). If born early/late, how many weeks at birth? | | | |
| Any problems during pregnancy (high blood pressure, preeclampsia, eclampsia, diabetes, placenta issues, etc.)? If yes, please explain. | | | |
| Any problem with delivery or after birth? If yes, please explain. | | | |
| Did the patient go to the NICU after delivery? If yes, please explain. | | | |
| Any problems in the nursery (jaundice, low blood sugar, feeding / breathing issues, etc.)? If yes, please explain. | | | |

## DEVELOPEMENTAL HISTORY

| | |
|---|---|
| Walk alone? Age: | First tooth loss? Age: |
| Talk (2 words)? Age: | Speech therapy? If so, what age did the patient start and end? |
| Toilet trained? Age: | OT? PT? If yes, what age did patient start and end? |
| First tooth erupted? Age: | |

**SOCIAL HISTORY**

Does the patient live with both biological parents? If no, please explain: _____

_____

What grade is the patient in? _____

Is the patient in regular classes, advanced classes (AP), have an IEP, have a 504 Plan, need extra help with certain subjects? (please circle and explain) _____

Are there any recent changes in school performance or academic concerns? If yes, please explain. _____

_____

_____

**MEDICAL HISTORY**

| |
|---|
| Any hospitalizations? If yes, please explain: |
| Any fractures? If yes, please explain: |
| Any surgeries? If yes, please explain: |
| Any major or chronic medical problems? If yes, please explain: |
| Does the patient have any allergies? If so, please explain: _____ _____ |

**CURRENT MEDICATIONS**

1._____ 5. _____
2._____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Do you take any supplements or herbals, including skin/hair products? If yes, please list: _____

_____

Do you take a multivitamin or Vitamin D? If yes, please indicate dose: _____

**DIET AND EXERCISE HISTORY**

What sport(s) is/are your child involved in? _____

On average, how many hours of screen time does the patient have each day (TV, video games, computer, tablet, phone)? _____

How often does the patient drink milk or other dairy products? None / rarely / 1 to 3 servings per day / more than 3 servings per day. Please circle best answer.

**FAMILY HISTORY**

Mother's height: _____ Father's height: _____ Sibling Height (age): _____
Sibling Height (age): _____ Sibling Height (age): _____ Sibling Height (age): _____
Sibling Height (age): _____ Sibling Height (age): _____ Sibling Height (age): _____

| ILLNESS | Mother | Father | Sibling | Sibling | Sibling | Maternal | | | | | Paternal | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | Grandmother | Grandfather | Aunt | Uncle | Cousin | Grandmother | Grandfather | Aunt | uncle | cousin |
| Diabetes: Type1 or Type 2 | | | | | | | | | | | | | | | |
| Thyroid illness | | | | | | | | | | | | | | | |
| Adult height under 5 ft (150 cm) | | | | | | | | | | | | | | | |
| Early or Late puberty | | | | | | | | | | | | | | | |
| Fertility problems | | | | | | | | | | | | | | | |
| PCOS, irregular periods | | | | | | | | | | | | | | | |
| Hypertension | | | | | | | | | | | | | | | |
| Overweight/Obesity | | | | | | | | | | | | | | | |
| Celiac disease, gluten intolerance | | | | | | | | | | | | | | | |
| Crohn's disease, ulcerative colitis | | | | | | | | | | | | | | | |
| Psoriasis | | | | | | | | | | | | | | | |
| Lupus | | | | | | | | | | | | | | | |
| Bone disease, abnormal fractures, teeth issues | | | | | | | | | | | | | | | |
| Joint issues (rheumatoid arthritis) | | | | | | | | | | | | | | | |
| Kidney stones | | | | | | | | | | | | | | | |
| Cancer (type) | | | | | | | | | | | | | | | |
| Heart disease | | | | | | | | | | | | | | | |
| Stroke | | | | | | | | | | | | | | | |
| Cholesterol problems | | | | | | | | | | | | | | | |
| Depression / Mood problems | | | | | | | | | | | | | | | |

**REVIEW OF SYSTEMS**
Please check if your child has had a history of any of the following:

☐ check if ALL systems are negative

GENERAL
- ☐ Poor weight gain
- ☐ Weight loss _____lbs. in _____months/years
- ☐ Tiredness
- ☐ Sweaty
- ☐ Appetite changes
- ☐ Feeding difficulty
- ☐ Developmental delay
- ☐ Slow growth
- ☐ Rapid growth

ENDOCRINE
- ☐ Always cold compared to others
- ☐ Always hot and sweaty compared to others
- ☐ Excessive thirst
- ☐ Excessive urination
- ☐ Excessive hunger
- ☐ Urinating at night _____times
- ☐ Salt craving
- ☐ Slow growth
- ☐ Rapid growth
- ☐ Adult body odor, if yes, what age_____
- ☐ Pubic hair, if yes, what age _____

BOYS
- ☐ Breast development

GIRLS
- ☐ Breast development, if yes, what age _____

Have menstrual cycles begun? If yes:
Age of onset: _____
Date of last period: _____
- ☐ Irregular menstruation
- ☐ Heavy menstruation

EYES
- ☐ Wears glasses or contact lenses
- ☐ Recent vision changes
- ☐ Eye redness or dry eyes

EARS/NOSE/THROAT
- ☐ Decreased hearing
- ☐ Hearing loss
- ☐ Decreased ability to smell
- ☐ Snoring, pauses in breathing (apnea)
- ☐ Difficulty or pain while swallowing
- ☐ Change in voice
- ☐ Frequent nosebleeds

RESPIRATORY
- ☐ Difficulty breathing
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Cough
- ☐ Chest pain
- ☐ Breathing assistance at night (CPAP)

HEART/BLOOD VESSELS
- ☐ Palpitations / heart racing
- ☐ High blood pressure
- ☐ Heart murmur
- ☐ Swelling of hands/feet
- ☐ Fainting

GASTROINTESTINAL
- ☐ Frequent abdominal pain
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea/loose stools
- ☐ Blood/mucus in stools
- ☐ Constipation/ hard infrequent stool
- ☐ Heartburn
- ☐ Coughing or gagging with eating

GENITOURINARY
- ☐ Frequent urination
- ☐ Getting up at night to void
- ☐ Bedwetting
- ☐ Pain or burning with urination

ALLERGY/IMMUNE SYSTEM
- ☐ Seasonal allergies
- ☐ Nasal congestion
- ☐ Sneezing

SKIN
- ☐ Acne
- ☐ Dry or oily skin
- ☐ Rash
- ☐ Change in skin color
- ☐ Stretch marks
- ☐ Hari growth on face, chest, belly (girls)
- ☐ Dry, brittle hair
- ☐ Hair loss
- ☐ Flushing
- ☐ Birthmarks (describe: _____ _____)

BLOOD/LYMPH
- ☐ Anemia
- ☐ Easy bruising or bleeding
- ☐ Enlarged lymph nodes

MUSCLES/BONES/JOINTS
- ☐ Muscle weakness or pain
- ☐ Muscle cramps
- ☐ Joint pain
- ☐ Bone pain

NEUROLOGIC
- ☐ Frequent headaches
- ☐ Seizures
- ☐ Tremor
- ☐ Dizziness
- ☐ Speech problems
- ☐ Head trauma

PSYCHIATRIC/BEHAVIORAL
OTHER
- ☐ Anxiety/nervousness
- ☐ Depression
- ☐ Mood swings
- ☐ Agitation/irritability

OTHER: _____
_____
_____
_____