WNY Pediatric ENDOCRINOLOGY

Patient Medical History Form

Patient Name: _____ Date of Birth: _____

Dear Parent,

Please answer the following questions, which are an important part of your child's evaluation. We appreciate your assistance.

Patient's Mother's History

How many pregnancies have you had? _____ How many living children? _____

Any childhood deaths in the family? ___ No ___ Yes (Cause of death: _____)

Length of pregnancy with this child: ___ Full term ___ Premature (_____weeks) ___ Post –term

While pregnant, did you use:

Medication (hormones, antibiotics, etc.) _____

Alcohol ___ No ___ Yes Cigarettes ___ No ___ Yes

Did you require fertility treatment to become pregnant? ___ No ___ Yes

Complications during pregnancy:

Infections ___ No ___ Yes High blood pressure ___ No ___ Yes

Diabetes ___ No ___ Yes Other complications ___ No ___ Yes, explain _____

Weight gain: _____ How long was your labor? _____

Type of delivery: Vaginal C-Section

Hospital your child was born? _____

Birth History

Birth weight: _____ Birth length: _____

Breathing problems ___ No ___ Yes Jaundice ___ No ___ Yes

Abnormal blood work ___ No ___ Yes Regular nursery or Intensive Care Unit? _____

Other problems? _____

Growth and Development

Any problems during the first month of life? ___ No ___ Yes, explain _____

How old was your child when he/she:

Walked:	Toilet Trained:
Talked:	School Grade:
1st Tooth:	

Illnesses: Please list your child's serious illnesses and the date they occurred:

_____

_____

_____

Hospitalizations: List why, when and where: □ NONE

_____

_____

_____

Surgeries: Please list surgery and date: □ NONE

_____

_____

_____

Medications: Please list current medications and dosage: □ NONE

_____

_____

_____

Allergies: Please list any medication, substance, or environmental allergies: □ NONE

_____

_____

Tell Us About Your Child

Who does your child live with? _____

Are child's parents: Married Divorced Separated Single

What activities does your child participate in? _____

_____

Are there any stressors at home or school that we should know about? _____

_____

Family History

Family Member	Age	Height	Onset of Puberty (male: age began shaving; female: age of menses)	Health Problems
Father				
Mother				
Brother/Sister				
Brother/Sister				
Brother/Sister				
Paternal Grandmother				
Paternal Grandfather				
Maternal Grandmother				
Maternal Grandfather				

If your child is being evaluated for short or tall stature, please list the height of:

Family Member	Height
Paternal Aunt/Uncle	
Paternal Aunt/Uncle	
Paternal Aunt/Uncle	
Maternal Aunt/Uncle	
Maternal Aunt/Uncle	
Maternal Aunt/Uncle	

Do you have any family members with:

Diabetes □ No □ Yes (insulin, pills & who: _____)

Heart Attack □ No □ Yes (deceased & who: _____)

High blood pressure □ No □ Yes (who: _____)

High cholesterol □ No □ Yes (who: _____)

Thyroid problems □ No □ Yes (who: _____)

Other □ No □ Yes (what & who: _____)

Please list Primary Physician/Pediatrician and any other specialist(s) seen:

Thank you for taking the time to fill out this form. The information is very important in determining a diagnosis and treatment plan for you or your child.

This form was completed by (your name): _____

Your relationship to patient: _____

For Office Use Only:
I have reviewed the information above.
Provider signature: _____ Date: _____