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? _____

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

While pregnant, did you use: Medication ____ No ____ Yes

Alcohol ___ No ___ Yes Cigarettes ___ No ___ Yes

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

Complications during pregnancy: ____ No ____ Yes

Birth History

Birth weight: _____ Birth length: _____

Any problems? _____

Growth and Development

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

Current Grade: _____

Any learning difficulties? ____ No ____ Yes, explain _____

Illnesses: Please list your child's serious illnesses:

_____

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 – (blood pressure, cholesterol, thyroid, diabetes, other)
Father				
Mother				
Brother/Sister				
Brother/Sister				
Brother/Sister				
Brother/Sister				
Brother/Sister				
Paternal Grandmother				
Paternal Grandfather				
Maternal Grandmother				
Maternal Grandfather				

Please list any other specialist(s) seen:

Please circle anything you are concerned about.

General:	Fever
	Tired
	Weight gain
	Weight loss
Eyes:	Vision changes
	Poor vision
Ears:	Trouble hearing
	Recent ear infections
Respiratory:	Cough
	Shortness of breath
Heart:	Chest pain
	Swelling of legs
	Racing heart rate
GI:	Constipation
	Diarrhea
	Nausea
	Hearburn
Hematology:	Bruising
	Swollen glands
Endocrine:	Hot
	Cold
	Increased thirst
Puberty:	Menstrual changes
	Concern about body changes
Urology:	Going to the bathroom frequently
Muscular:	Joint pain
	Joint swelling
	Sore muscles
Neurology:	Headache
	Seizures
	Dizziness
Skin:	Rash
	Skin changes
Psychological:	Sad
	Overwhelmed
	Anxiety

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: _____