Blank Children's Hospital
UnityPoint Health

Please complete and bring to the first visit

PATIENT PROFILE
Pediatric Endocrinology

Name: _____ _____ _____ DOB: _____
(First) (Middle) (Last)

Parent/Guardian completing form: _____

Current Complaint:

1. What is the concern that brings your child to our clinic?

_____

_____

2. Who is concerned and when were you first aware of the problem?

_____

3. Has there been any change in nature/severity since you initially noticed the condition?
☐increased ☐decreased ☐none ☐other/explain: _____

4. Is there any other blood-related relative with a similar complaint, past or present?
☐No ☐Yes - If yes, list who and when?_____

_____

Pregnancy/Birth History:

1. Please check any of the following that applied during pregnancy with your child.
☐high blood pressure ☐high blood sugar ☐bleeding ☐infection ☐smoking
☐poor weight gain ☐use of alcohol ☐use of illegal drugs ☐other:_____

2. Use of medications (If any, please list) ☐Prenatal vitamins

_____

3. How many times have you been pregnant? _____

4. Previous miscarriages or abortions? ☐No ☐Yes - If yes, how many?_____

5. Was your child born ☐at due time ☐late ☐early? _____ weeks

a. Please check all that applies regarding the delivery:
☐vaginal ☐induced vaginal ☐C-section ☐vacuum extraction ☐forceps ☐other:_____

b. If a C-section, indicate reason: ☐large baby ☐repeat ☐distressed baby ☐other:_____

6. Birth weight: _____ Birth length: _____ Head: _____ Apgars scores: _____

7. Were there any problems during/directly after delivery? ☐No ☐Yes, please explain:

_____

8. Did your baby stay in the hospital for a health problem? ☐No ☐Yes, please explain:

_____

9. Did your baby have any problems during the first 3 months of life? ☐No ☐Yes, describe:

_____

Nutritional history:

1. Was your child breast-fed? ☐No ☐Yes, how long? _____
2. Was your child given formula? ☐No ☐Yes, how long? _____ What kind? _____
3. At what age was your child introduced to other foods? _____
4. Do you feel your child is ☐normal weight ☐underweight ☐overweight
5. What is your child's current diet? ☐normal ☐other: _____
6. How many servings of dairy products per day? _____
7. Any reactions, intolerance or allergies to any foods? ☐No ☐Yes, list: _____

Past Medical History:

1. Has your child ever had any serious illnesses or medical conditions? (please list)

_____

_____

2. Has your child ever been hospitalized? ☐No ☐Yes, indicate when, where and why:

_____

_____

_____

3. Has your child ever had surgery? ☐No ☐Yes, indicate when, where and what surgery:

_____

_____

4. Has your child ever had a serious accident? (i.e. car accident, broken bone, head injury)
☐No ☐Yes, please explain: _____
5. Is your child taking any medication? (prescription, over the counter, vitamins and herbals)
☐No ☐Yes, name and dose: _____

_____

6. Is your child allergic to any medication? ☐No ☐Yes, list the medication and reaction:

_____

7. Are your child's immunizations up to date? ☐Yes ☐No ☐Don't know ☐Needs:_____

Developmental History:

1. At what age did your child achieve the following milestones?
   - Rolled over _____ Sat without support _____ Walked alone _____ ☐Delayed motor skills
   - Smiled _____ Spoke in 2-3 word sentences _____ ☐Delayed language development
   - First baby tooth _____ Lost first tooth _____ Toilet trained _____
2. Did your child develop normally? ☐Yes ☐No, please explain:

_____

3. How old are your child's playmates? _____
4. Does your child have any learning or behavior problems? ☐No ☐Yes, please describe:

_____

Pubertal Development (if applicable):

1. What was the first sign of puberty that you observed? _____ At what age? _____
2. What age did your child have her first menstrual period? _____ ☐Non-applicable
3. List any concerns about puberty: _____

Review of Systems:

Does your child have problems with any of the following:

Unusual Fatigue	Y	N	Headache	Y	N	Heart or Blood Pressure	Y	N
Eyes or Ears	Y	N	Dizzy or Tremor	Y	N	Lungs	Y	N
Nose or Throat	Y	N	Seizure	Y	N	Bones/Muscles/Joints	Y	N
Neck	Y	N	Abdominal Pain	Y	N	Seasonal Allergies	Y	N
Lymph Nodes	Y	N	Vomiting or Reflux	Y	N	Skin/Hair	Y	N
Anemia	Y	N	Bowel Problems	Y	N	Sleep Problems	Y	N
Immune System	Y	N	Urinary Tract	Y	N	Psychiatric	Y	N

Explain any "yes" answers:

_____

_____

_____

_____

_____

Social History:

1. My child lives with ☐Mother & Father in same home ☐Mother ☐Father ☐Other:

_____

2. Mother's occupation: _____ Father's occupation: _____
3. My child attends ☐Day care ☐Preschool ☐School, name and grade: _____
4. Does your child receive any services? (special ed., resource, AEA, therapy, counseling, etc.)

_____

5. In what activities does your child participate?

_____

_____

Please Fill Out Family History on the Back of This Page

Family History: Please fill in where necessary and check all the apply.

Relationship to Child	Name	Age	Age of First Period (Females) or Age When Stopped Growing (Males)	Height	Weight	No Known Problems	Unknown	Anemia	Autoimmune Disease	Birth Defects	Cancer	Delayed Puberty	Developmental Delays	Type 1 Diabetes	Type 2 Diabetes	Early Puberty	Fertility Problem	Growth Problem	Heart Disease	High Cholesterol	High Blood Pressure	Mental Illness	Overweight	Seizures	Short Stature	Thyroid Disease	Other
Mother																											
Father																											
Sister																											
Brother																											
Maternal Aunt																											
Maternal Uncle																											
Paternal Aunt																											
Paternal Uncle																											
Maternal Grandmother																											
Maternal Grandfather																											
Paternal Grandmother																											
Paternal Grandfather																											

Notes: