NorthShore
University HealthSystem

Medical Group

Pediatric Endocrinology and Diabetes
New patient Form

Patient Information		
Patient's Name:		Today's Date:
Patient's age:	Patient's Date of Birth:	Patient's gender:
Relationship of person completing form:		
Age when concern started:	Referred by: [ ]Physician Name:	
Any tests, labs or x-rays completed related to today's visit? [ ]yes [ ]No Where were they performed? When?		
Has the child been seen by an endocrinologist previously? [ ]No [ ]Yes, When?		
Did your child's primary physician recommend this visit? [ ] Yes [ ] No		
Main reason for visit today?		

Parent Guardian Information	
Parent One Name:	Best contact number:
Parent Two Name:	Best contact number:
Home Address:	Home Phone:
City:	Zip Code:
Parent One Occupation:	
Parent Two Occupation:	
Emergency Contact Name:	Best contact number:
Relationship to child:	

Custody
Parents are: [ ]Married [ ]Separated [ ]Divorced
If divorced or separated, who has legal custody?
Are any of the parents restricted (must provide legal paperwork) from being included or provided medical information about the patient? [ ] Yes [ ]No

Pediatrician Information		
Physician's Name:	Phone:	
Address:	City:	Zip code:
Fax if known:		

School Information	
[ ]Not applicable, go to next section	Grade level:
Any learning disabilities [ ]No [ ]Yes, please explain:_____	Therapies child is receiving (check all that apply) [ ]OT [ ]PT [ ]Speech therapy [ ]Tutoring in:
Performance: [ ]As expected [ ]Below expected [ ]Above expected	

Birth Information	
Were there any concerns during pregnancy? [ ]No [ ]Yes, please list below	
Full term [ ]Yes [ ]No, # of weeks _____	[ ]Child adopted, history not known
Birth weight: _____ lbs. _____ oz.	Birth length: _____ inches
Any problems during delivery? [ ]No [ ]Yes If Yes, explain:	
Did child require breathing assistance at birth? [ ]No [ ]Yes	
Did the child go to the ICU? [ ]No [ ]Yes	If yes, how many days and reason: ___ Days for:
[ ]Breast milk [ ]Formula [ ]Special formula	Diet/weight concerns? [ ]No [ ]Yes
Did your child have any developmental delays? [ ]No [ ]Yes, please list:	

Medical History
Current medications, vitamins or supplements child takes?
Name: Dose:
Name: Dose:
Name: Dose:
Name: Dose:
Does the child have any drug allergies? [ ]No [ ]Yes
Drug name: Reaction:
Drug name: Reaction:
Drug name: Reaction:

Hospitalizations / Emergency Room Visits
Has your child been hospitalized overnight? [ ]No [ ]Yes
Date of stay? # of Nights _____ Reason:
Date of stay? # of Nights _____ Reason:

Surgeries [ ]No [ ]Yes list below:	
Year	**Type of Surgery**

Medical History		
Does your Child show signs of Sexual Development (Puberty)? [ ]Yes [ ]No		
If yes, at what age did you first notice the following in your child? (List age)		
Body odor _____years old	Underarm Hair _____years old	Acne _____years old
Facial hair _____years old	Pubic hair _____years old	

Female Patients	
Breast budding/tenderness _____years old	First bleeding period _____years old

Male Patients	
Growth of penis or testicles _____years old	Voice deepening _____years old

All Patients - Other Medical Concerns		
Does your child have concerns with any of the following: (provide details below)		
Dark or pale skin spots or birthmarks?	[ ]Yes [ ]No	Details:
Headaches, seizures, or loss of consciousness?	[ ]Yes [ ]No	Details:
Broken bones or head injuries?	[ ]Yes [ ]No	Details:
Vision concerns?	[ ]Yes [ ]No	Details:
Hearing loss or ear infections?	[ ]Yes [ ]No	Details:
Loss/heightened sense of smell?	[ ]Yes [ ]No	Details:
Eating (swallowing or appetite) concerns?	[ ]Yes [ ]No	Details:
Heart of blood pressure concerns?	[ ]Yes [ ]No	Details:
Asthma? If known list severity level in details.	[ ]Yes [ ]No	Details:
Other medical condition/s:		Details:

Relevant Family History			
[ ]**Section not applicable –** family history is not known for child.			
	Age	**Height**	**Puberty**
Father			Reached final height at ___yrs
Mother			First Period at ____ yrs
Sibling:			
Sibling:			
Sibling:			

Does anyone on either side of the family have a medical problem with anything listed below?	Choose (yes or no)	List relationship (i.e., brother, sister, mother, father, grandparent, cousin)
Diabetes	[ ]Yes [ ]No	
Thyroid or goiter	[ ]Yes [ ]No	
Short stature	[ ]Yes [ ]No	
Late or early puberty	[ ]Yes [ ]No	
Adrenal hormone problem	[ ]Yes [ ]No	
Unable to have children	[ ]Yes [ ]No	
High or low calcium problems	[ ]Yes [ ]No	
Child died early	[ ]Yes [ ]No	
High Cholesterol	[ ]Yes [ ]No	
High blood pressure	[ ]Yes [ ]No	
Tumor in childhood?	[ ]Yes [ ]No	
Heart attack or stroke before 55 years of age	[ ]Yes [ ]No	
Other Information		
Please list any other information that you feel is important for us to know:		

IF YOUR CHILD HAS A PROBLEM WITH HEIGHT OR WEIGHT, THEN ***BRING ALL GROWTH RECORDS*** FROM HOME, SCHOOL, AND CHILD'S PHYSICIAN

Return this form to:

Pediatric Endocrinology

9977 Woods Drive, Suite 300

Skokie, IL 60077

Phone: 847.663.8508

Fax: 847.663.8515

Please note: appointments cancelled and/or rescheduled less than 24 business hours in advance will result in a ***$100.00*** charge.