



**PEDIATRIC ENDOCRINE ASSOCIATES, P.C.**

1100 Lake Hearn Drive, Suite 350  
Atlanta, GA 30342

Endocrinology and Diabetes  
of Children and Adolescents

Telephone (404) 255-0015  
Fax #: (404) 845-3080

Patient Number: \_\_\_\_\_

Date of First Visit: \_\_\_\_\_

**PATIENT HISTORY QUESTIONNAIRE**

NAME \_\_\_\_\_ Birthdate \_\_\_\_\_

Street Address \_\_\_\_\_ Sex: M F

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone Number \_\_\_\_\_ Cell \_\_\_\_\_ Email \_\_\_\_\_

Father \_\_\_\_\_ Occupation \_\_\_\_\_

Business Phone \_\_\_\_\_ Cell \_\_\_\_\_ Social Security # \_\_\_\_\_

Mother \_\_\_\_\_ Occupation \_\_\_\_\_

Business Phone \_\_\_\_\_ Cell \_\_\_\_\_ Social Security # \_\_\_\_\_

Referring Physician \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Patient's School \_\_\_\_\_ Grade \_\_\_\_\_

Why have you (or your child's physician) requested an endocrine evaluation? What special concerns have you had about your child? (USE ADDITIONAL SHEET IF NECESSARY)

**PREGNANCY AND NEWBORN HISTORY**

Did you carry your child for the full 9 months? Yes \_\_\_\_\_ No \_\_\_\_\_

If no, how many weeks? early \_\_\_\_\_ late \_\_\_\_\_

Weight gained during pregnancy: \_\_\_\_\_ Pounds

Child's Birth Weight: \_\_\_\_\_ LB \_\_\_\_\_ OZ Child's Birth Length: \_\_\_\_\_ Inches

Medications during pregnancy: \_\_\_\_\_

Problems during pregnancy: Illnesses \_\_\_\_\_

Infections \_\_\_\_\_

Bleeding \_\_\_\_\_

Morning Sickness \_\_\_\_\_

None \_\_\_\_\_ Other \_\_\_\_\_

Labor: spontaneous \_\_\_\_\_ induced \_\_\_\_\_  
length of labor \_\_\_\_\_ hours  
any difficulties \_\_\_\_\_

Delivery: vaginal \_\_\_\_\_ C-section \_\_\_\_\_ (why? \_\_\_\_\_ )  
Position of baby - head first \_\_\_\_\_ feet first \_\_\_\_\_ other \_\_\_\_\_  
Were forceps used? Yes \_\_\_\_\_ No \_\_\_\_\_  
Were you awake? Yes \_\_\_\_\_ No \_\_\_\_\_  
Any difficulties? \_\_\_\_\_

Any breathing problems at birth? Yes \_\_\_\_\_ No \_\_\_\_\_  
Did your child have "yellow" jaundice? Yes \_\_\_\_\_ No \_\_\_\_\_  
Did your child come home from the hospital with you? Yes \_\_\_\_\_ No \_\_\_\_\_  
Was your child: breast-fed \_\_\_\_\_ bottle-fed \_\_\_\_\_

**DEVELOPMENT**

At what age did your child:

Sit \_\_\_\_\_ Say first words \_\_\_\_\_  
Crawl \_\_\_\_\_ Get first tooth \_\_\_\_\_  
Stand \_\_\_\_\_ Lose first tooth \_\_\_\_\_  
Walk \_\_\_\_\_

At what age was your child toilet-trained? \_\_\_\_\_

Girls: Age and date (if known) of first menstrual period \_\_\_\_\_

**PAST HEIGHTS AND WEIGHTS AT VARIOUS AGES** (extremely important, particularly for growth problems.) Can be obtained from your child's physician(s) or the school nurse.

<u>Date</u>	<u>Height</u>	<u>Weight</u>	<u>Date</u>	<u>Height</u>	<u>Weight</u>
-------------	---------------	---------------	-------------	---------------	---------------

**PAST HEALTH**

Has your child ever had (and at what age?):

Regular Measles \_\_\_\_\_ Mumps \_\_\_\_\_  
German Measles \_\_\_\_\_ Scarlet Fever \_\_\_\_\_  
Chicken Pox \_\_\_\_\_ Other \_\_\_\_\_

Any serious or chronic illness during childhood? \_\_\_\_\_

Any serious falls or injuries, including any broken bones? \_\_\_\_\_

Any hospitalization for illness or evaluation of a medical (non-surgical) problem? (Also, give hospital and child's age): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Any operations? (Give hospital and child's age): \_\_\_\_\_  
 \_\_\_\_\_

Had your child had all the immunizations necessary for his or her age? Yes \_\_\_\_\_ No \_\_\_\_\_  
 Is your child on any medications? No \_\_\_\_\_ If Yes, what are they? \_\_\_\_\_

**KNOWN ALLERGIES:** \_\_\_\_\_

Has your child ever complained of or been seen by a physician for any of the following?

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Dizziness                  | <input type="checkbox"/> Frequent vomiting                     | <input type="checkbox"/> Skin problems                |
| <input type="checkbox"/> Headaches                  | <input type="checkbox"/> Feeding problems                      | <input type="checkbox"/> Difficulty tolerating cold   |
| <input type="checkbox"/> Blurred or abnormal vision | <input type="checkbox"/> Urine infections                      | <input type="checkbox"/> Difficulty tolerating heat   |
| <input type="checkbox"/> Hearing problems           | <input type="checkbox"/> Frequent urination                    | <input type="checkbox"/> Chronic fatigue              |
| <input type="checkbox"/> Ear infections             | <input type="checkbox"/> Painful urination                     | <input type="checkbox"/> Hyperactivity                |
| <input type="checkbox"/> Frequent sore throats      | <input type="checkbox"/> Undescended testicles                 | <input type="checkbox"/> Anemia                       |
| <input type="checkbox"/> Frequent colds             | <input type="checkbox"/> Hernias                               | <input type="checkbox"/> Sleeping problems            |
| <input type="checkbox"/> Pneumonia                  | <input type="checkbox"/> Abnormal periods                      | <input type="checkbox"/> Abnormal weight loss or gain |
| <input type="checkbox"/> Asthma                     | <input type="checkbox"/> Weakness of muscles                   | <input type="checkbox"/> Psychological problem        |
| <input type="checkbox"/> Heart murmur               | <input type="checkbox"/> Tingling or numbness in hands or feet | <input type="checkbox"/> High Cholesterol             |
| <input type="checkbox"/> Frequent diarrhea          | <input type="checkbox"/> Seizures or convulsions               | <input type="checkbox"/> Other _____                  |
| <input type="checkbox"/> Frequent constipation      | <input type="checkbox"/> Fainting spells                       | _____   |

**FAMILY HISTORY**

Please give the birthdate, age, weight, current health and if female, age of first menstrual period, of the following family members:

FAMILY MEMBER	Year of Birth	Age	Height	Weight	Current Health	If female, Age at First period
Father						
Mother						
Patient's Brother's						
Patient's Sisters						
Father's Father						
Father's Mother						
Mother's Father						
Mother's Mother						

If being seen for a growth problem, list below heights of aunts and uncles on both father's and mother's sides:

Was any immediate family member or relative a "late grower", "late bloomer", or slow developer in their teenage years? If so, whom? \_\_\_\_\_

Do any of these problems run in your family? (indicate mother's or father's side)

Diabetes ("Sugar"): insulin-requiring \_\_\_\_\_  
non-insulin requiring \_\_\_\_\_

Thyroid problems: underactive \_\_\_\_\_  
overactive \_\_\_\_\_

Heart disease \_\_\_\_\_ High cholesterol \_\_\_\_\_

High Blood Pressure \_\_\_\_\_ Kidney Problems \_\_\_\_\_

Low Blood Sugar \_\_\_\_\_ Bowel Problems \_\_\_\_\_

Other \_\_\_\_\_

Who lives at home with your child?

Are there any significant family problems in your household? (Marital, financial, etc.)

Does your child get along well with his/her family and friends?

What is the age of your child's playmates or friends?

How does your child do in school?

What are your child's hobbies and interests?

Are there any emotional problems related to your child's medical reason for seeing us? (Use additional sheet if necessary)

Is there any other information we should be aware of?

Thank you for completing this questionnaire. It will help us greatly in evaluating your child's problem.

Robert M. Schultz, MD  
Melissa A. Carlsson, MD  
Gayathri Dasari, MD

Stephen W. Anderson, MD  
Mark S. Rogerson, MD  
Constance Baldwin, MD