Atrium Health Levine Children's Pediatric Endocrinology & Diabetes Specialists

PLEASE COMPLETE BOTH SIDES

Date: _____ Patient Name: _____ DOB: _____

SOCIAL HISTORY

Are parents _____Married _____Separated _____Divorced _____Never Married
Who lives with patient? _____
Patient in daycare? Y/N Grade level in school_____ School performance_____
Mother's occupation: _____ Father's occupation: _____
Smokers in home? Y/N

FAMILY HISTORY

RELATION TO PATIENT	AGE	HEIGHT	WEIGHT	HEALTH PROBLEMS
Mother				
Maternal grandmother				
Maternal grandfather				
Father				
Paternal grandmother				
Paternal grandfather				
Sibling (brother/sister)				
Sibling (brother/sister)				
Sibling (brother/sister)				

Please list OTHER family members with the following diseases:

DISEASE	Relationship to patient
Adrenal disease	
Asthma/allergies	
Calcium problems/osteoporosis	
Diabetes	
Cholesterol problems	
Heart attacks or strokes before 50	
High blood pressure	
Kidney problems	
Thyroid disease	
Tumors/cancers (list type)	
Stomach/colon problems	
Vitiligo	
Please list other diseases:	

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PAST MEDICAL HISTORY

Was the patient _____Full-term _____Pre-term Weeks gestation: _____
Method of delivery _____Vaginal _____C-section
Please list any medicines mother took during pregnancy: _____
Did mother drink alcohol? Y/N Number of drinks per day _____
Did mother smoke? Y/N Number of packs per day _____
Birth Weight: _____ Complications: _____

Please list any major medical conditions the patient has: _____
_____
_____
_____

Surgeries and dates: _____
_____

Other hospitalizations, dates, and reasons: _____
_____
_____

Allergies to Medications: _____
Other allergies: _____

Please list all prescription medications, over-the-counter medications, vitamins, supplements and herbs currently used by patient

DRUG	DOSE (amount and how often)	How long used?

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Patient Name _____ **DOB:** _____

Development

How old was your child when he/she started walking? _____ Talking? _____
Were there any delays in development?

_____

_____

How old was he/she when his/her first tooth erupted? _____ First adult tooth? _____
Has growth/height been steady? _____

Has the patient experienced any of the following symptoms recently? (please check box)

Symptom	Yes	No	N/A	Symptom	Yes	No	N/A
Weight loss				Hair loss or changes			
Weight gain				Muscle or joint problems			
Headaches				Limping			
Vision problems				Seizure(s)			
Hoarseness				Weakness			
Hearing problems				Loss of consciousness			
Multiple ear infections				Head trauma			
Heart problems				Broken bones			
Kidney problems				Yeast infections			
Trouble swallowing				Always hot or cold			
Chest pain				Anxiety or Depression (circle)			
Shortness of breath				Average hours of sleep nightly?			
Heart palpitations				Fatigue			
Constipation or Diarrhea				Trouble sleeping			
Pneumonia				Wheezing			
Blood in stool				Chronic cough			
Abdominal pain				Snoring			
Blood in urine				Bladder infections			
Excessive thirst				Does patient smoke?			
Excessive urination				Household smokers?			
Recurrent fevers				How is the child's appetite?	**Poor**	**Average**	**Good**
Pain with urination				Age at first menstrual cycle:			
Skin Problems				Are your periods regular?			

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Diet History: **List typical foods eaten for the following**

Breakfast:
Lunch:
Dinner:
Snacks:
Drinks:

Activities:

Type of exercise:
How many days per week?
How many hours of screen time (computer, video games, TV) Weekdays_____ Weekend days_____

If you are being seen today for diabetes, please ALSO complete below.

How often per week are you having low blood sugar levels requiring assistance (circle): 0 1-3 >3

Have you had puffiness or infections at injection/infusion sites? (circle) Yes No

Where do you give your injections/place infusion sets? _____

Have you had any pump malfunctions? (circle) Yes No

When was your last eye exam? (Month/Year) _____

When was your last dental exam? (Month/Year) _____

When was your last flu vaccine? (Month/Year) _____

How many days of school (or work for parents) have been missed in the past 3 months due to diabetes? _____

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