Cook Children's Medical Center

Date:_____

Patient Name: _____ DOB: _____

Name of Person Completing Form: _____

Relationship to Patient:_____

Primary Care Physician: _____

Referring Physician: _____

Preferred Pharmacy: _____

Reason For Today's Visit

Please list the reason for your child's visit to the endocrine clinic:

_____

_____

Current Medications

Please list any medications along with the dose that your child is currently taking. Please include over the counter medications.

Medication	Dose	Medication	Dose

Allergies

Please list any food or drug allergies that your child has along with the reaction from exposure.

Allergy	Reaction

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Social History

Please answer the questions below by circling or filling in the appropriate response.

Question	Answer (circle or fill in the blank)	Explanation
Does your child have any barriers to learning or communication?	Yes No	
How does your child prefer to learn?	Discussion Demonstration Return demonstration Reading Watching a video Communication board Sign language Other N/A – infant or toddler	
What is your child's preferred language?		
Do the child's caregiver(s) have any barriers to learning or communication?	Yes No	
How do the caregiver(s) prefer to learn?	Discussion Demonstration Return demonstration Reading Watching a video Communication board Sign language Other	
What is the caregiver(s) preferred language?		
Has your child had all of their scheduled immunizations?	Yes No	
Does your child have any developmental delays (physical or mental)?	Yes No	
Who does your child live with?		
Who is your child's primary and secondary caretaker?		
Mother's Occupation		
Father's Occupation		
Have there been any recent changes to your child's family/social situation?	Yes No	
What is the marital status of the parents of the child?	Married Divorced Separated Other	
What is your child's general stress level?	Low Moderate High	
Are there financial stressors in the home?	None Mild Moderate Severe	
Do you utilize childcare for your child? If so, what kind?	Daycare Preschool Private Sitter Relative Other	

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What grade is your child currently in?		
What type of school does your child attend?	Public School Private School Home School Other	
What types of grades does your child generally make in school?	Good Fair Poor	
Does your child attend any resource or special education classes?	Yes No	

Prenatal/Birth History

Please answer the questions below by circling or filling in the appropriate response.

Question	Answer (circle or fill in the blank)	Explanation
Was your child full term at birth?	Yes No	
How many weeks gestation was your child at birth?		
What was your child's weight at birth?	____lbs ____oz	
What was your child's length at birth?	____in	
How was your child delivered?	Vaginal C- Section	
Were there any complications associated with the pregnancy of your child?	Yes No	
Were there any medications taken during the pregnancy with your child?	Yes No	
Were there any complications during the birth of your child?	Yes No	

Family Growth & Puberty History

Please answer the questions below by circling or filling in the appropriate response.

Family Member	Age	Height	Weight	Puberty Please Circle
Father				Early Normal Delayed
Mother				Early Normal Delayed • Mothers age at first period____

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Family Member	Age	Height	Weight
Brother			
Brother			
Brother			
Sister			
Sister			
Sister			
Paternal Grandfather Father's father			
Paternal Grandmother Father's mother			
Maternal Grandfather Mother's father			
Maternal Grandmother Mother's mother			

Physical Activity History

Please answer the questions below by circling or filling in the appropriate response.

Question	Answer (circle or fill in the blank)	Explanation
What is your child's exercise/activity level?	Sedentary Moderately Active Very Active	
Does your child participate in sports?	Yes No	
What type of exercise does your child get?		

Adolescent Questions (13 & Up)

Please answer the questions below by circling or filling in the appropriate response.

Question	Answer (circle or fill in the blank)	Explanation
Does your child use alcohol?	Yes No	
Does your child use tobacco?	Yes No	
Does your child use illicit drugs?	Yes No	
Is your child sexually active? If yes, please list any contraception or barriers used.	Yes No	

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Family Health History

Please let us know if any of your child's family members have been diagnosed with any of the medical problems listed below.

Medical Problem	Yes/No	If Yes, Who
Abnormal Blood Fats		
Addison's Disease/Adrenal Problems		
Anxiety/Depression/Mental Illness		
Asthma		
Blood Clotting Disorder		
Cancer		
Celiac Disease		
Congenital Adrenal Hyperplasia		
Cushing Syndrome		
Cystic Fibrosis		
Deafness		
Diabetes- Type 1		
Diabetes- Type 2		
Diabetes- Unknown		
Heart Attack		
Angioplasty or stent (artery of the heart)		
High Blood Pressure		
High Cholesterol		
Hypoglycemia		
Kidney Stones		
Neurofibromatosis		
Overweight/Obesity		
Previous bariatric surgery		
Osteoporosis/Bone Fractures		
Pheochromocytoma (Adrenal tumor)		
Pituitary Tumors		
Rickets		
Seizures		
Short Stature		
Stroke or TIA (mini stroke)		
Procedure to open carotid artery in neck		
Thyroid Disease		
Thyroid Cancer		
Other		

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Growth/Developmental History

Please answer the questions below by circling or filling in the appropriate response.

Milestone	Age	Additional Information
Walked Alone		
First Words		
Toilet Training Completed		
First Baby Teeth		
First Permanent Tooth		
Current Age of Playmates		

Past Medical History

Has your child ever been treated for any of these medical problems?

Medical Problem	Yes/No	If Yes, Please Explain
ADD/ADHD		
Allergies		
Anxiety/Panic Disorder		
Asthma/Recurring Wheezing		
Bipolar Disorder		
Blood Clotting Disorder		
Celiac Disease		
Cerebral Palsy		
Chromosomal Abnormality		
Congenital Abnormality		
Congenital Heart Disease		
Cystic Fibrosis		
Dandy Walker Malformation		
Deafness		
Depression		
DiGeorge Syndrome		
Down Syndrome		
Failure To Thrive		
Gastroesophogeal Reflux Disease		
High Blood Pressure		
High Cholesterol		
Kidney Stones		
Klinefelter Syndrome		
McCune Albright Syndrome		
Neurofibromatosis		
Obstructive Sleep Apnea		
Prader- Willi Syndrome		

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Past Surgical History

Please list any previous surgeries that your child has had along with the date of surgery.

Surgery/Procedure	Date Of Surgery/Procedure

Hospitalizations/Serious Injuries

Please list any hospitalizations and serious injuries that your child has been treated for.

Hospitalization/Serious Injury	Date Of Hospitalization/Injury

Please list any other concerns about your child that we should be aware of.

_____
_____
_____
_____
_____
_____

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