Pediatric Endocrine Associates
New Patient Questionnaire
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Please complete this questionnaire. If you cannot answer a question, leave it blank. All information will be kept confidential, as part of the patient's medical record.

Patient's Name: _____ Today's Date:_____

Birth Date:_____ Age: _____

Name of parent(s)/guardian(s):_____and_____

Name of doctor who referred you to us:_____

1. Reason for referral:

In your own words, what medical problem(s) can we help you with?

_____

_____

_____

_____

2. **Review of Systems:** Please indicate any problems with the following and explain if "yes"

Energy/Activity	No ☐	Yes ☐ _____	Drinking	No ☐	Yes ☐ _____
Sleep	No ☐	Yes ☐ _____	Urination	No ☐	Yes ☐ _____
Moods	No ☐	Yes ☐ _____	Bowels	No ☐	Yes ☐ _____
Ear,Nose,Throat	No ☐	Yes ☐ _____	Nausea/Vomiting	No ☐	Yes ☐ _____
Vision	No ☐	Yes ☐ _____	Blood/Lymph	No ☐	Yes ☐ _____
Cardiovascular	No ☐	Yes ☐ _____	Allergy/Immune	No ☐	Yes ☐ _____
Respiratory	No ☐	Yes ☐ _____	Neurologic	No ☐	Yes ☐ _____
Headaches	No ☐	Yes ☐ _____	Psychiatric	No ☐	Yes ☐ _____
Growth	No ☐	Yes ☐ _____	Urogenital	No ☐	Yes ☐ _____
Appetite	No ☐	Yes ☐ _____	Musculoskeletal	No ☐	Yes ☐ _____
Weight Gain	No ☐	Yes ☐ _____	Sense of Smell	No ☐	Yes ☐ _____
Skin Problems	No ☐	Yes ☐ _____	Menstruating	No ☐	Yes Age ☐ _____
Other Problems	No ☐	Yes ☐ _____	Frequency/Duration:		_____

☐ Reviewed

3. Prenatal History: *During the pregnancy, did mother*: Please indicate and explain if "Yes"

Smoke? No Yes_____ Have vaginal bleeding? No Yes_____

Drink alcohol? No Yes_____ Infections? No Yes_____

Use medications? No Yes_____ Diabetes? No Yes_____

Use Hormones? No Yes_____ High blood pressure? No Yes_____

Have xrays? No Yes_____ Thyroid problems? No Yes_____

How much weight did mother gain during the pregnancy?_____

How many months was the pregnancy?_____

What was the birthweight?_____Birthlength?_____

Type of Delivery: Vaginal C-section Presentation: Head first Breech

Delivery Complications: No Yes_____

_____

Newborn problems: NONE JAUNDICE HYPOGLYCEMIA TEMPERATURE INSTABILITY

FEEDING DIFFICULTY OTHER: please explain_____

NICU ADMISSION: No Yes How long did the child remain in NICU?_____

What did baby eat? BREASTMILK FORMULA Age at wean?_____

4. Medical History: Please indicate and explain if "Yes"

Injuries: No Yes/Age_____

Surgeries: No Yes/Age_____

Hospital stays: No Yes/Age_____

Allergies: No Yes/Reaction_____

Medical issues: No Yes/Age_____

Medicines: No Yes/Dose_____

5. **Development:** At what age did these happen? or may check ⟶ ALL NORMAL

Sat up_____months Said mama/dada_____months

Standing_____months Walked alone_____months

Talked in sentences_____months Potty trained_____months

Please explain if any problems:_____

☐ Reviewed

6. **Family History:** Please fill in the blanks

	Age	Height	Weight	Age at puberty	Health
Mother	_____	_____	_____	_____	_____
Father	_____	_____	_____	_____	_____
Sister	_____	_____	_____	_____	_____
Brother	_____	_____	_____	_____	_____
Sister/Brother	_____	_____	_____	_____	_____
Sister/Brother	_____	_____	_____	_____	_____
Maternal grandfather	_____	_____	_____	_____	_____
Maternal grandmother	_____	_____	_____	_____	_____
Paternal grandfather	_____	_____	_____	_____	_____
Paternal grandmother	_____	_____	_____	_____	_____

Does anyone in the family have: Please indicate and explain if "Yes"

Diabetes	No	Yes/Type_____	Too short	No	Yes_____
Thyroid disease	No	Yes_____	Too tall	No	Yes_____
Late puberty	No	Yes_____	Heart disease	No	Yes_____
Early puberty	No	Yes_____	Hi blood pressure	No	Yes_____
Cancer	No	Yes/Type_____	Hi Cholesterol	No	Yes_____
Obesity	No	Yes_____	Other Problems		Yes_____

7. **Social history:**

Who does the patient live with:

Parent(s) occupation: Mom_____ Dad_____

Child's school:_____ Grade level:_____

Performance:_____Repeated grades:_____

Behavior:_____PE: No Yes Daily exercise: No Yes

Extracurricular Activities:_____

Time spent watching TV or using computer:(not related to school) _____hours/day

Does your child eat fruits and vegetables? No Yes How many servings per day_____

Does your child drink milk or eat dairy? No Yes How many servings per day_____

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