

PEDIATRIC ENDOCRINE QUESTIONNAIRE

Patient's Name: _____ **DOB:** _____

Date of Visit: _____ **MRN:** _____

Physician: _____

<p>Pediatrician Information: Name: _____ Address: _____ _____ _____ Phone: _____ Fax: _____</p> <p>Referring Physician Information: Name: _____ Address: _____ _____ _____</p>
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Would you like a report of your visit sent to your Pediatrician and/or Referring Doctor? Y N

PLEASE TELL US ABOUT YOUR CHILD

BIRTH HISTORY:

Was your child born premature? Y N
If YES, how many weeks/months: _____
What was the birth weight: _____

Any problems during pregnancy? Y N
If YES, please explain: _____

Any problems after birth? Y N
If YES, please explain: _____

MEDICAL HISTORY:

Does your child have any chronic condition(s)? Y N
If YES, please explain: _____

Does your child take any medication on a regular basis? Y N
If YES, please complete:

Name of Medication	Dosage
_____	_____
_____	_____
_____	_____

Has your child ever been admitted to a hospital? Y N
If YES, please complete:

Reason for Admission	Date/Age	Hospital
_____	_____	_____
_____	_____	_____
_____	_____	_____

Has your child ever had any surgery? Y N

If YES, please complete: Type of Surgery Date/Age Hospital/Doctor

_____	_____	_____
_____	_____	_____
_____	_____	_____

FAMILY HISTORY:

Mother's Height: _____

Father's Height: _____

Does anybody in your family have/had:

	NO	YES	Family Member(s)
Diabetes requiring insulin	<input type="checkbox"/>	<input type="checkbox"/> -	_____
Diabetes treated w/oral medication or diet	<input type="checkbox"/>	<input type="checkbox"/> -	_____
Hypothyroidism	<input type="checkbox"/>	<input type="checkbox"/> -	_____
Other Thyroid problem	<input type="checkbox"/>	<input type="checkbox"/> -	_____
Irregular menses	<input type="checkbox"/>	<input type="checkbox"/> -	_____
Infertility problem	<input type="checkbox"/>	<input type="checkbox"/> -	_____
Sudden death in the family	<input type="checkbox"/>	<input type="checkbox"/> -	_____
Other chronic illnesses	<input type="checkbox"/>	<input type="checkbox"/> -	_____

REVIEW OF SYSTEMS:

Does your child have/had:

	NO	YES	Please Explain:
Respiratory problems	<input type="checkbox"/>	<input type="checkbox"/> -	_____
Frequent infections	<input type="checkbox"/>	<input type="checkbox"/> -	_____
Frequent vomiting	<input type="checkbox"/>	<input type="checkbox"/> -	_____
Diarrhea/Constipation	<input type="checkbox"/>	<input type="checkbox"/> -	_____
Recent weight loss	<input type="checkbox"/>	<input type="checkbox"/> -	_____
Recent significant weight gain	<input type="checkbox"/>	<input type="checkbox"/> -	_____
Frequent urination/ urination at night	<input type="checkbox"/>	<input type="checkbox"/> -	_____
Excessive thirst	<input type="checkbox"/>	<input type="checkbox"/> -	_____
Frequent headaches	<input type="checkbox"/>	<input type="checkbox"/> -	_____
Visual problems	<input type="checkbox"/>	<input type="checkbox"/> -	_____
Hearing problems	<input type="checkbox"/>	<input type="checkbox"/> -	_____
Frequent fractures	<input type="checkbox"/>	<input type="checkbox"/> -	_____
Acne/Extra facial or body hair/ hair loss	<input type="checkbox"/>	<input type="checkbox"/> -	_____
Learning difficulties at school	<input type="checkbox"/>	<input type="checkbox"/> -	_____
Emotional/Behavioral problems	<input type="checkbox"/>	<input type="checkbox"/> -	_____

Are you concerned about your child's diet? Y N

If YES, please explain: _____

(Please answer following only if there are concerns regarding diet)

Please describe his/her diet on a typical day: Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: How many/day? _____

Type of foods: _____

Drinks:	NO	YES	Ounces per day
Regular soda	<input type="checkbox"/>	<input type="checkbox"/>	- _____
Fruit Juices	<input type="checkbox"/>	<input type="checkbox"/>	- _____
Milk	<input type="checkbox"/>	<input type="checkbox"/>	- _____

Do you have any other concerns about your child? Y N

If YES, please explain: _____

SOCIAL HISTORY

For infants and toddlers: Who is the primary caregiver? _____

Does the child attend nursery? Y N

For school age children: Grade: _____ Special School Y N

Specific School Concerns if any: _____

Is there any concern about the family that we need to need to know? Y N

If YES, please explain: _____

Please tell us the best way to contact you if we need to reach you regarding results. (Complete all relevant)

	Mother	Father	Other
Home Phone: () _____ - _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> - _____
Cell Phone: () _____ - _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> - _____
Work Phone: () _____ - _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> - _____

Can we leave a message regarding results on your answering machine? Y N

Name of person completing this questionnaire: _____

Relationship to patient: _____

IF YOU ARE HERE FOR GROWTH EVALUATION, PLEASE GIVE US A COPY OF THE GROWTH CHART. (Does not apply to children who are followed by Cornell Faculty Practice)