DIVISION OF PEDIATRIC ENDOCRINOLOGY
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The Herman & Walter Samuelson Children's Hospital at Sinai
a LifeBridge Health center

Welcome to our office. In order to facilitate your child's evaluation, we'd appreciate you providing us with the following information:
Date of appointment: _____

Child's full name: _____ **Date of Birth:** _____
Nickname? _____

Name of your child's primary care physician/pediatrician: _____

Physician's Address:_____

Phone # _____ Fax # _____

Who referred you to our office (if different from physician above)? _____

Name and phone number of your preferred pharmacy: _____

Why are you coming to see us today? _____

_____

Has your child had any medical tests performed due to this condition (X-rays, blood, urine, stool tests, etc.)? ☐ Yes ☐ No

If yes, when/where? _____

Medical History:

Medical problems or health concerns:

1. _____
2. _____
3. _____
4. _____

Prior hospitalizations (Reason/Date/Location):

1. _____
2. _____

Prior surgeries or outpatient procedures (Surgery name/Date/Location):

1. _____
2. _____

Please list any known medication, food, or other allergies: _____

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Current Medications:

Medication name	Dose	Frequency (How often it is given)

Birth History:

Any problems with pregnancy, labor, or delivery? _____

Child's birth weight: _____ birth length: _____ Gestational age: _____ weeks

In the first week of life, was the baby jaundiced? ☐ Yes ☐ No

Any medical problems during first month of life?_____

Social History:

Who lives at home with your child?_____

Has your child traveled outside the U.S. in past 6 months?_____

Current grade in school: _____

Any unusual stresses at home or school? _____

Family History:

	height	weight	age	health	meds	Age of puberty
father						
mother						
sibs						

Please place a check mark in the appropriate box if any of the listed family members have a condition listed below:

Condition	Mother	Father	Brother	Sister	Maternal grandmother	Maternal grandfather	Paternal grandmother	Paternal grandfather
Diabetes								
Celiac disease								
Thyroid disease								
Short stature								
Bone disease								

Abnormal puberty								

Are there any other medical conditions that run in the family that are not mentioned above?_____

_____

Review of Systems:

Please check the box below if your child has experienced any of the following in the past three months:

General	□poor growth	□Fatigue	□fever	□ Weight loss or gain	□ other
Skin	□ Rashes	□ Jaundice	□ Other:		
Eyes	□ Vision problems:	□ Other:			
Ear, nose, throat	□ Hearing loss	□ Nasal discharge	□ Strep throat	□ Mouth sores	□ other
Heart	□ fast heart beat	other			
Chest	□ Wheezing	□ Chest pain	□ Coughing	□ Other	
Hematology	□ Bleeding problems	□ Bruises easily	□ Other		
Genitourinary	□ Bed wetting	□ Painful urination	□ increased urination	□ Other	
Musculoskeletal	□ Joint pain	□ Joint stiffness	□ Joint swelling	□ Fractures	□ Other
Neurological	□ Headache	□ Loss of consciousness	□ Seizures	□ Dizziness	□ Other

Has your child been diagnosed with any of the following? Please check all that apply.

□ Asthma	□ ADHD/ ADD
□ Heart Murmur	□ Anxiety
□ Anemia	□ Depression
□ Diabetes	□ Other: _____