Coastal Kids
Endocrinology & Weight Management

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Please complete the following as best you can prior to the visit:

GENERAL INFORMATION:

Patient's Name:	Child's age:
Patient's Date of Birth	Today's Date:
Name of Preferred Pharmacy and address:	

Why is the child being seen?

BIRTH HISTORY:

Birth Weight:	Birth Length:	☐ Vaginal Delivery	☐ C-Section-why?
☐ Full-term / Born early / Late – How many weeks?			
☐ Any problems during pregnancy (high blood pressure, preeclampsia, eclampsia, diabetes, placenta issues, etc)? ☐ NO ☐ YES Explain:			
Any problem with the delivery or after birth? ☐ NO	☐ YES –Explain	☐ jaundice	☐ low blood sugar
Did the child go to the ICU after delivery? ☐ NO	☐ YES – Explain:	☐ breathing issues	

MEDICAL HISTORY:

Any hospitalizations? ☐ NO	☐ YES List:
Any fractures? ☐ NO	☐ YES List:
Any surgeries? ☐ NO	☐ YES List:
Other medical problems/ diagnoses? ☐ NO	☐ YES Explain:

DEVELOPMENTAL HISTORY:

Walk alone ☐ Age:	Other services needed?
Speech therapy? ☐ NO ☐ YES	First tooth erupted ☐ Age:
OT or PT? ☐ NO ☐ YES	First baby tooth loss ☐ Age:

SOCIAL HISTORY:

Does child live with both biological parents? ☐ Yes ☐ No - Explain:	
Grade:	☐ Home schooled ☐ Regular class ☐ gifted ☐ IEP ☐ 504 plan ☐ needs extra help with certain subjects ☐ Recent changes in school performance

ALLERGIES: ☐ NO ☐ YES, specify: _____

MEDICATION INFORMATION:
Current medications:

_____ _____
_____ _____
_____ _____

Multivitamins: ☐ NO ☐ YES ☐ SPORADIC
Vitamin D supplements: ☐ NO ☐ YES, dose: _____
Other supplements: _____

DIETARY CALCIUM INTAKE:
Milk/milk alternative, other dairy/day
☐ none
☐ rarely
☐ 1-2 per day ☐ 2-3 per day
☐ 2-3 per day ☐ >3 per day
☐ >3 per day source
☐ other calcium

FAMILY HISTORY

	Height	**Timing of puberty** (early, average, late / **age** of menses)	**Illnesses**
Mother			
Father			
Siblings: age ☐ brother ☐ sister			
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*(*Mat.= maternal- mom's side *Pat.= paternal- dad's side; all is in relation to **patient**)*

Illness	**Relatives**		☐ other:
Diabetes- Type 1 or Type 2	*Mat. ☐GF ☐GM ☐aunt ☐uncle	*Pat. ☐GF ☐GM ☐aunt ☐uncle	
Thyroid illness	*Mat. ☐GF ☐GM ☐aunt ☐uncle	*Pat. ☐GF ☐GM ☐aunt ☐uncle	
Adult height under 5 ft or under 150 cm	*Mat. ☐GF ☐GM ☐aunt ☐uncle	*Pat. ☐GF ☐GM ☐aunt ☐uncle	
Early or late puberty	*Mat. ☐GF ☐GM ☐aunt ☐uncle	*Pat. ☐GF ☐GM ☐aunt ☐uncle	
Fertility problems	*Mat. ☐GF ☐GM ☐aunt ☐uncle	*Pat. ☐GF ☐GM ☐aunt ☐uncle	
PCOs, irregular periods	*Mat. ☐GF ☐GM ☐aunt ☐uncle	*Pat. ☐GF ☐GM ☐aunt ☐uncle	
Celiac disease, gluten intolerance	*Mat. ☐GF ☐GM ☐aunt ☐uncle	*Pat. ☐GF ☐GM ☐aunt ☐uncle	
Crohn's disease, ulcerative colitis	*Mat. ☐GF ☐GM ☐aunt ☐uncle	*Pat. ☐GF ☐GM ☐aunt ☐uncle	
Lupus	*Mat. ☐GF ☐GM ☐aunt ☐uncle	*Pat. ☐GF ☐GM ☐aunt ☐uncle	
Psoriasis	*Mat. ☐GF ☐GM ☐aunt ☐uncle	*Pat. ☐GF ☐GM ☐aunt ☐uncle	
Bone disease (abnormal fractures), teeth issues	*Mat. ☐GF ☐GM ☐aunt ☐uncle	*Pat. ☐GF ☐GM ☐aunt ☐uncle	
Early joint issues (rheumatoid arthritis)	*Mat. ☐GF ☐GM ☐aunt ☐uncle	*Pat. ☐GF ☐GM ☐aunt ☐uncle	
Kidney stones	*Mat. ☐GF ☐GM ☐aunt ☐uncle	*Pat. ☐GF ☐GM ☐aunt ☐uncle	
High blood pressure	*Mat. ☐GF ☐GM ☐aunt ☐uncle	*Pat. ☐GF ☐GM ☐aunt ☐uncle	
Overweight/Obesity	*Mat. ☐GF ☐GM ☐aunt ☐uncle	*Pat. ☐GF ☐GM ☐aunt ☐uncle	
Cancer (type)	*Mat. ☐GF ☐GM ☐aunt ☐uncle	*Pat. ☐GF ☐GM ☐aunt ☐uncle	
Heart disease	*Mat. ☐GF ☐GM ☐aunt ☐uncle	*Pat. ☐GF ☐GM ☐aunt ☐uncle	
Stroke	*Mat. ☐GF ☐GM ☐aunt ☐uncle	*Pat. ☐GF ☐GM ☐aunt ☐uncle	
Cholesterol problems	*Mat. ☐GF ☐GM ☐aunt ☐uncle	*Pat. ☐GF ☐GM ☐aunt ☐uncle	
Depression/Mood problems	*Mat. ☐GF ☐GM ☐aunt ☐uncle	*Pat. ☐GF ☐GM ☐aunt ☐uncle	

HAS YOUR CHILD BEEN EXPERIENCING ANY OF THE FOLLOWING? :

- □ tiredness _____
- □ poor weight gain _____
- □ weight loss_____lbs in ____ □ months/□ years (time frame)
- □ weight gain_____lbs in ____ □ months/□ years (time frame)
- □ appetite changes _____
- □ slow growth (height/length) _____
- □ rapid growth (height) _____
- □ always cold compared to others _____
- □ always hot and sweaty compared to others _____
- □ headaches _____
- □ changes in vision _____
- □ wearing glasses or contacts: □ no □ yes- for how many years? _____
- □ eye(s) redness or dryness _____
- □ difficulty or pain swallowing _____
- □ palpitations/heart racing _____
- □ shortness of breath _____
- □ snoring: □ no □ yes; pausing in breathing (apnea) noted? □ no □ yes – prior sleep study? □ no □ yes
- □ abdominal pain _____
- □ constipation, hard infrequent stools _____
- □ diarrhea, frequent or loose stools _____
- □ blood in stools _____
- □ nausea _____
- □ vomiting _____
- □ heartburn _____
- □ coughing or gagging with eating _____
- □ getting up at night to void _____
- □ bedwetting _____
- □ excessive thirst _____
- □ frequent urination _____
- □ pain or burning with urination _____
- □ any pubertal changes noted? □ no □ yes – what? _____
- □ menses: □ no □ yes – age when the first period? _____
- □ periods □ irregular □ regular_____□ the first day of the last period? _____
- □ discharge from breast(s) _____
- □ join pain or swelling _____
- □ bone pain _____
- □ muscle cramps _____
- □ tremor/shaking _____
- □ skin changes _____
- □ hair loss or other hair changes _____
- □ other