Children's Diabetes and Endocrine Center						
Patient's Name Date of birth:						
Reason for visit						
Family Medical His	-		111 49 9			
•	mation on your child's	s family membe	rs and identify if a	any nave tr	ne following	g
conditions:	Name	Age	Height	Thyroid	Short	Diabetes
	Name	Age	(only parents)	TTIYTOIG	stature	Diabetes
Biological Father						
Biological Mother						
Sibling						
Sibling						
Sibling						
	th history: Birth le					
	oted? Yes No		-)
	, <u> </u>	•	9	•		
How old were you w	hen your baby was b	orn?	_			
Did you have any illr	nesses when you wer	e pregnant?				
Did your baby have	any difficulty at birth?					
What type of deliver	y did you have? 🔲 '	Vaginal 🗌 C-S	Section			
Medical History:						
Current medications	(include all medication	ons including vit	amins, herbs and	d suppleme	ents)	
Medication name	Dose		Frequency		Last tak	en

Does your child have any allergies to medications? If so, which ones and what reaction do they have?

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Has your child had any hospitalizations, surgeries or special medical tests? If yes, give approximate date and location of services. Has your child had any significant health problems we need to know about? When was your child's last eye exam? _____ last dental exam? _____ Has your child experienced any of the following? (please check the box if they have) □ Unusual tiredness ☐ Joint/muscle pain ☐ Changes in sleeping habits ☐ Limited mobility ☐ Too hot or too cold ☐ Muscle weakness □ Appetite changes ☐ Numbness, tingling in feet and hands □ Weight changes ☐ Pubertal changes □ Nightmares ☐ Menstrual irregularities (if applicable) ☐ Change in growth rate ☐ Body odor ☐ Increased thirst/urination □ Vision changes ☐ Diarrhea/Constipation ☐ Glasses or contacts □ Stomachaches ☐ Frequent nosebleeds □ Dental problems □ Nausea/Vomiting ☐ Late eruption of teeth □ Increased urination ☐ Ear infections ☐ Chest pain ☐ Headaches ☐ High blood pressure ☐ Seizures/convulsions ☐ Rapid heart rate ☐ Breathing difficulty/snoring ☐ Developmental problems □ Asthma ☐ Behavior changes ☐ Sleep apnea ☐ School problems ☐ Skin dryness or changes ☐ Depresssion □ Other ☐ Acne ☐ Darkened areas of skin ☐ Abnormal hair growth/loss