MedStar Georgetown University Hospital

Department of Pediatrics
Division of Endocrinology
New Patient Information Form

PATIENT NAME: _____ **DATE OF BIRTH:** _____

TODAY'S VISIT:

What is the reason for your visit? _____

When was this concern noticed? _____

Specific Questions or Concerns: _____

_____

BIRTH HISTORY:

Born: early / on time / late Born at: _____ weeks

Birth weight: _____ Birth length: _____

Complications during pregnancy or delivery: _____

Exposure to alcohol, smoke or drugs during pregnancy:_____

Medications taken by mother during pregnancy: _____

MEDICAL HISTORY:

Did your child meet early developmental milestones on time (sitting up/walking/talking)? Yes / no

Allergies: _____ Dental development: Normal / delayed

Past Medical History: _____

Current Medications: _____

Hospitalizations/ Surgeries/ Trauma: _____

SOCIAL HISTORY

Who lives in the patient's home? _____

Grade Level: _____ School: _____

Do you have any concerns about academic performance? _____

Is your child physically active? Yes / No Extracurricular Activities: _____

Does she/he feel comfortable socially? _____

Have there been recent changes or stresses at home? _____

Exposure to smoking: _____ Pets: _____

Referring Provider:
Phone:

Practice Name:
Fax:

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PATIENT NAME: _____ **DATE OF BIRTH:** _____

FAMILY MEDICAL HISTORY

MOTHER: Age _____ Height _____ Age of first menstrual cycle: _____

Mother's Health Problems: _____

FATHER: Age _____ Height _____ Puberty: early / normal / late

Father's Health Problems: _____

Siblings: yes / no Age(s) _____

Siblings Health Problems: _____

Health Problems of Mother's Parents: _____

Health Problems of Father's Parents: _____

Family History of thyroid problems, diabetes, growth or puberty disorders, autoimmune conditions:

yes no If yes, please explain: _____

REVIEW OF SYSTEMS

General	**Yes**	**No**	**Eyes, Ears, Nose & Throat**	**Yes**	**No**
Weight Changes			Blurry Vision		
Fatigue			Corrective Lenses		
Sleep Problems			Hearing Problems		
Snoring			Frequent Ear Infections		
Frequent Illnesses			Decreased Sense of Smell		
Appetite Changes					
Excessive Sweating					
Respiratory			**Heme**		
Wheezing			Anemia		
Difficulty Breathing			Easy bruising		
Snoring					
Neurological			**Cardiovascular**		
Seizures			High Blood Pressure		
Headaches			Chest Pain		
Difficulty Concentrating			Rapid/racing heart rate		
Endocrine			**Skin & Hair**		
Excessive Thirst			Dry Skin		
Low blood sugar			Jaundice		
Intolerance to heat			Acne		
Intolerance to cold			Hair Loss		
Breast enlargement			Excessive Hair Growth		
Age of breast development ____			Facial Hair		
Age of pubic hair onset ____			Many birthmarks (moles)		
Age of first menstrual period ____			Skin Color Changes		
Genitourinary			**Musculoskeletal**		
Frequent Urination			Muscle aches		
Bedwetting			Muscle weakness		
Urinary Tract Infections			Broken bones		
Gastrointestinal			**Psych**		
Constipation			Mood changes		
Diarrhea			Family stress		
Nausea/Vomiting			Behavioral issues		
Abdominal Pain			School issues		

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