EndoHealth
ENRICHING CHILDREN'S LIVES

GAYATHRI DEVINENI M.D.

New Patient History

Name: **DOB:** **Grade:**

What was the reason you (or your child's physician) requested an endocrine evaluation? What are your concerns?

CHILD's HISTORY:

Pregnancy &New born history: Was your pregnancy full term (9months)? Yes / No

If no, how many weeks? Early ___________ Late ____________
Child Birth weight: ____________ Pounds __________ OZ Child Birth Length: ______________inches

Problems during pregnancy: None __________

Morning sickness: ____________________ Other: ________________________

Bleeding: __________________________ Infection: ___________________________

Labor: Spontaneous ______________ Induced _____________

Any difficulties ____

Delivery: Vaginal _____________ C-Section______________ (Why __________________________)

VBAC _____________ Forceps ________________ Any difficulties? __________________

Any problems for the baby at birth? ____

Did your child go home with you? ____

Was your child: Breast -fed / Bottle fed _____________ Jaundice _____________________________

DEVELOPMENT: At what age your child:

Sit: ______________ Say first words _______________ Crawl: ___________________

Get first tooth _____________ Stand: __________________ Lose First tooth ____________________

Walk ___________________ Potty Trained _________________________

ALLERGIES: ____ **IMMUNIZATIONS Up to date**: Yes / No.

Past Heights & Weights: (This portion is very important, if your concern is your child's growth). You can obtain this information from your child's pediatrician(s) or the school nurse.

Date	Age	Height	Weight	Date	Age	Height	Weight

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Past Health: Any chronic condition? ____
Medications: ____

Has your child ever had any of the following (and at what age)?

RSV: _______________ Mumps: ________________ German Measles: ___________________

Scarlet fever: ________________ Regular Measles: _______________ Other: _____________________

Any serious fall / injuries: ____

Hospitalization for illness or evaluation of a problem? (please give hospital & child's age):

____

Any operations? (Please give hospital & child's age): _________________________

____

Has your child ever had or been seen by a physician for any of the following?

___ Headache ___ Urine infection ___ Difficulty tolerating cold ___ Dizziness ___ Frequent urination
___ Asthma ___ Anemia ___ Difficulty tolerating heat ___ Hernias ___ Painful urination
___ Chronic fatigue ___ Frequent colds ___ Hyperactivity ___ Frequent Diarrhea
___ Frequent sore throats ___ Undescended Testicles ___ Fainting spells ___ Ear infections
___ Frequent Vomiting ___ Skin problems ___Hearing problems ___ Feeding problems
___ Excessive Sweating ___ Frequent Constipation ___ Abnormal Periods ___ High Cholesterol
___ Heart murmur ___ Weakness of Muscles ___ Psychological problems ___ Tingling/numbness
___ Abnormal weight loss or gain ___ Seizures / Convulsions ___ Pneumonia
___ Blurred or abnormal vision ___ Other _______________

FAMILY HISTORY: Please give date of birth, age, weight, current health. If female age of first menstrual period of the following family members:

FAMILY MEMBER	Year of Birth	Age	Height	Weight	Current Health	If female, Age of First period
Father						
Mother						
Brothers						
Sisters						
Paternal Grandfather						
Paternal Grandmother						
Maternal Grandfather						
Maternal Grandmother						

Girls: Age and date (if known) of first menstrual period ___________________

If being seen for a growth problem, list below heights of aunts and uncles on both parents' sides, if known:

______________________ ______________________ ______________________

______________________ ______________________ ______________________

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FAMILY HISTORY CONTINUED:

Any immediate family member or relative that was a “late grower” or “late bloomer”, or was a slow developer in their teenage years? If so, who? ______________________________

Any of these problems run in the family? Cancer: ______________________________

Diabetes: ________ Type: _________ How is it controlled? Shots, oral medication or a combination? ___________

High B/P: __________________ High Cholesterol: ____________________ Heart disease: ___________________

Low blood sugar: ________________________ Kidney problems: ___________________________________

Bowel Problems: ________________________ Other: ____

Who else lives at home with your child?

Any significant family problems in your house hold? (marital, financial etc.)

How does your child do in school?

Does your child get along well with his/her family & friends?

What is the age of your child’s playmates or friends?

What are your child’s hobbies and interests?

Is there any other information we should be aware of?

Are there any emotional problems related to your child’s medical reason for seeing us?

Thank you for completing this questionnaire. It will help us greatly in evaluating your child’s problem.

G. Devineni

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