

Department of Endocrinology Child Health History Page 1 of 3

DO NOT WRITE IN THIS SPACE

Place Patient Label Here

NAME	DOB/
REFERRING PHYSICIAN	HOME PHONE
Best number to reach you at during the day (if different from home phone):	
OCCUPATIONS: Father:	Mother:
REASON FOR VISIT:	
PRENATAL/BIRTH HISTORY/INFANCY:	
Birth weight lb oz	
Was child born within 2 weeks of due date? ☐ No ☐ Yes	If no, how many weeks early?
Any medications taken during pregnancy? ☐ No ☐ Yes If y	
Tobacco use? ☐ No ☐ Yes Alcohol use? ☐ No	
<u> </u>	sarean section
Did the baby stay longer than the mother in the hospital?	⊔ Yes
If yes, why?	
Other problems in the newborn period (jaundice, feeding, breathing, infection, low blood sugar)	
Was the child breast-fed? \square No \square Yes If yes, for how	long?
DEVELOPMENT:	W/_11_0
At what age did your child first stand alone?	Walk?
Say more than 3 words?	Toilet train?
What grade is your child attending now?	☐ Yes If yes, describe
Is your child having problems with studies and grades? No	☐ Yes II yes, describe
Does he/she attend special classes or get home schooled? ☐ No	□ Voc
Does he/she attend special classes of get nome schooled? \(\sigma\) No	□ 1es
MEDICAL HISTORY:	
Has your child ever been hospitalized? No Yes If yes, give ages and reasons	
Thas your child ever been hospitanized: 11 10 11 1es 11 yes, gr	ve ages and reasons
Any other health problem, including behavioral (e.g. ADHD)? ☐ No ☐ Yes	
The case near process, increasing control (e.g. 110110):	
Has your child ever had outpatient surgery? □ No □ Yes	
This your child ever had outpatient surgery: in two in tes	
Is your child on any medications? □ No □ Yes If yes, list year started and dosage	
Has your child been on steroid or ADD medications in the past?	



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Does your child have any drug allergies? □ No □ Yes		
Food/environmental allergies? □No □Yes		
Circle the infections your child has had and give age at most recent episode		
Chicken pox / whooping cough / bronchiolitis / mumps / strep throat / mono		
FAMILY HISTORY:		
Mother: HeightWeight Age of first period Health problems		
Father: Height Weight Puberty: early / average / late Health problems		
List the child's brothers and sisters (indicate if they are half-sibs): sex, age, and indicate size and puberty as		
appropriate (also include any no longer living and cause of death)		
If child is being seen for short stature, please provide heights of:		
Maternal grandmother Maternal grandfather		
Paternal grandmother Paternal grandfather		
Are there any other relatives who are unusually short? \square No \square Yes If yes, who and how short?		
Is there a family history of thyroid problems? \square No \square Yes Diabetes? \square No \square Yes		
If yes, give type of problem and age at diagnosis if known		
Is there a family history of high blood pressure, high cholesterol, early heart attacks (before age 50), depression, or		
bowel disease? No Yes		
Any other conditions which seem to run in your family? Tho Tyes		
SYSTEMS REVIEW: If yes to any question, describe and indicate the duration of each complaint when possible.		
You may use the space at the bottom of page 3 if needed.		
General: Has there been recent rapid weight gain? No Yes		
Has there been recent weight loss? No Ver Yes If so, how many lbs?		
Is child unusually tired or sluggish? ☐ No ☐ Yes		
Does child feel too warm or too cold much of the time? No Yes		
Is child thirsty all the time? No Yes		
Eyes: Has child had more trouble seeing lately (e.g. sits very close to TV)? No Yes		
Has child mentioned blurred vision or double vision? No Yes		
Have the eyes been crossed? No Yes		



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Ears, nose, and throat:	
Has child had frequent ear infections? ☐ No ☐ Yes	
Are there problems with hearing?	
Is there ongoing nasal congestion or nosebleeds? — No — Yes	
Does your child snore loudly at night? ☐ No ☐ Yes	
Is there often difficulty swallowing? \(\superscript{No \superscript{Yes}}\)	
Chest: Has there been frequent cough?	
Does child get short of breath or tires very easily? \(\triangle \text{No} \) \(\triangle \text{Yes} \)	
Does child have a heart murmur?	
Does child complain of heart beating rapidly? ☐No ☐Yes	
Abdomen: Any history of yellow jaundice outside of newborn period? No Yes	
Does child have frequent loose bowel movements? The Tyes	
Is child frequently constipated? No Yes	
Is there frequent vomiting? ☐No ☐Yes	
Does child have blood in bowel movements or very dark bowel movements? \(\subseteq \text{No} \) \(\subseteq \text{Yes} \)	
Are there frequent stomach pains which come and go? \(\subseteq\) No \(\subseteq\) Yes	
Urinary tract: Has there been frequent bedwetting? No L Yes	
Does child have frequent urination day and night? \(\subset\) Yes	
Is there often pain or burning with urination? Tho Tyes	
Skin: Is there excessive sweating? PNo PYes	
Is there any chronic skin rash? No TYes	
Any change in skin color? Tho Tyes	
Is hair coarse or is it falling out? No Yes	
Bones, joints, muscles: Are there painful, stiff, or swollen joints? \(\backslash \text{No} \backslash \text{Yes} \)	
Pain in muscles or over bone? \(\bar{\text{No}} \bar{\text{Yes}} \)	
Has there been a decrease in muscle strength? PNo PYes	
Neurological: Does child have frequent headaches?	
Have there been any seizures or fainting spells? Tho TYes	
Reproductive (Girls only) Has there been any blood or discharge from vagina? Vo Ves	
Has she had her first period? □ No □ Yes If yes, at what age?	
Are the periods irregular or very painful? No Yes	
Is there any discharge or fluid from breasts?	
NOTES:	