CHILDREN'S
HEALTH SYSTEM
1600 7th Avenue South
Birmingham, AL 35233

Admit Date: PT #:

MR#: Clinic:
DOB: Age: Sex: Race:
Attending Dr: Dr.#:
Referring Dr:

WELCOME TO THE DIABETES/ENDOCRINE CLINIC

Dear Family:

We would like to take a few moments to tell you how important you and your child are to our clinic. Please allow us to explain a few of the common reasons we see patients and why there may be delays. A typical office visit may take a minimum of 2-2 ½ hours. The Endocrinology Clinic see's a large volume of patients for a broad spectrum of reasons. Here are a few of the most common reasons why:

1. A child with New-Onset Diabetes or a regular Diabetes follow up may have the following done:
   a. Evaluation by M.D. or Nurse Practitioner
   b. Have intensive teaching by Diabetes Educator
   c. Have teaching by our Nutritionist
   d. Speak with our Social Worker
   e. Have labs drawn

2. A child here for growth related issues may have the following done:
   a. Evaluation by M.D. or Nurse Practitioner
   b. If indicated, be scheduled for outpatient testing or MRI
   c. Have labs drawn and X-ray

3. A child here with pituitary/adrenal/thyroid condition may have the following done:
   a. Evaluation by M.D. or Nurse Practitioner
   b. Intensive teaching by M.D., Nurse Practitioner, or Nurse Clinician
   c. Stimulation tests (for specific adrenal patients) which require timed labs and medication administration

We are glad that you have chosen us to provide specialized care for your child. It is our goal to provide that care safely and efficiently. We understand that your time is valuable, and will do everything in our power to ensure that you are seen as close to your appointment time as possible. If you feel that your wait is too long, we will be happy to reschedule your appointment. Please take advantage of the report cards given out in the patient packets. Let us know how we're doing!

If you have questions or concerns about your clinic visit, please feel free to call:
The Children's Hospital Department of Endocrinology at 205-939-9107 or The Children's Hospital Patient Relations Department at 205-939-9191

Thursday, June 07, 2012

Admit Date: PT #:

MR#: Clinic:
DOB: Age: Sex: Race:
Attending Dr: Dr.#:
Referring Dr:

The Children's Hospital of Alabama
Pediatric Endocrinology/Diabetic Clinic
New Patient History

Name: ______________________________ DOB: ______________
Mother's Name: ______________________________
Father's Name: ______________________________

Address: ______________________________
____

Telephone (H): ______________ (W): ______________
Referring MD: ______________________________

Current Complaint:

What brings your child to our clinic today: ______________________________
____
____

When did you first notice the problem? ______________________________
____

Has there been any change in the problem (i.e. getting better/worse)? ______________
____

Are there any blood relatives with a similar complaint: ______________________________
____

Past Medical History:

Has your child ever had any major illnesses or injuries requiring hospitalizations? If so, please list and date:
____
____
____
____

Does your child have any chronic illnesses (i.e. asthma, allergies, seizures, etc.)?
____
____
____

Has your child ever had any surgeries (including circumcision)? If so, please list and date:
____
____
____
____

Is your child on any medications? If so, please list ______________________________
____
____

Is your child allergic to any medications? ______________________________
____

Are you child's immunizations up to date? □ Yes □ No

____
MD Initials

Form #10

CHILDREN'S HOSPITAL®

Admit Date: PT #:

MR#: Clinic:
DOB: Age: Sex: Race:
Attending Dr: Dr.#:
Referring Dr:

Pregnancy/Birth History

Did you have any problems during your pregnancy? ______________________________

____

____

How many times have you been pregnant? ____ Age at this pregnancy? ______________

Any previous miscarriages/abortions? _____ If yes, how many? ____________________

Was your child born □ early □ on time □ late

Type of delivery (vaginal, C-section, forceps, etc.)? ______________________________

Birth weight ____________________ Birth length ____________________

Any problems during/after delivery? ______________________________________

____

How long did your child stay in the hospital after birth? ____________________________

Nutritional History

Was your child: breastfed? ________ How long? ________

Formula fed? ______ Type? ________ How long? ____________________

Describe your child's current diet ____

____

____

Developmental History

Did your child develop normally? □ Yes □ No, please explain: ____________________

____

____

Does your child have any learning disabilities? □ Yes □ No, please describe

____

Pubertal Development

What was the first sign of puberty you observed and at what age? ____________________

____

At what age did your child start periods? ____

What is the duration of periods and how far apart are her cycles? ____________________

____

Any problems with her periods? ____

____

Social History

Who currently resides in your child's home? ____

____

Is your child in school/daycare? Please indicate what grade____________________________

____

To your knowledge, has your child ever used alcohol, tobacco or drugs? ____________________

____

____
MD Initials

CHILDREN'S HOSPITAL®

Admit Date: PT #:

MR#: Clinic:
DOB: Age: Sex: Race:
Attending Dr: Dr.#:
Referring Dr:

Family History

Please fill out to the best of your knowledge:

	Age	HT	Wt	Health Problems	Age at Puberty onset
Mother					
Father					
Brother/Sister					
Brother/Sister					
Brother/Sister					

Maternal Relatives:

Mother					
Father					
Brother/Sister					
Brother/Sister					
Brother/Sister					

Paternal Relatives:

Mother					
Father					
Brother/Sister					
Brother/Sister					
Brother/Sister					

Does any individual in the family have any of the follow: Diabetes, short/tall stature, menstrual irregularities, late/early puberty, infertility, thyroid disease, calcium problems, parathyroid problems, adrenal problems. Please list condition and relation to your child:____________________

____

____

Are there any other diseases that are inherited or run in the family? Please list ____________________

____

Review of Systems

Please indicate if your child has any of the following symptoms (circle all that apply)
Any system not marked is considered negative.

Recent fever	Weight loss/gain	Sleep problems	Fatigue
Headaches	Loss of appetite poor smell	Irritability	Hyperactivity
Visual changes	Cough	Palpitations	Tremors
Neck Swelling	Vomiting	Shortness of breath	Abd pain
Nausea	Freq. urination	Diarrhea	Constipation
Bedwetting	Joint pains	Excessive drinking	Weakness
Seizures	Hair loss	Fractures	Rash
Excess hair	Cold intolerance	Birth marks	Nail changes
Dry Skin		Heat intolerance	Behavior