Rocky Mountain Diabetes Center

New Pediatric Patient

Patient Name:	DOB:	Gender: ☐ Male ☐ Female
Home Phone:	Mobile Phone:	Email:
Person completing this form:	Relation to Patient:	
Reason for referral (chief complaint):		
Primary Care Provider:	Referring Provider:	
Other Doctors seeing your child:		
List all medications (with doses) your child is taking:		
Medication/Environmental Allergies:		
Immunizations: ☐ Up to date ☐ Not up to date Flu shot within the past 12 months? ☐ Yes ☐ No		

Laboratory / X-ray / Ultrasound / MRI

In the past year, has your child had any of the following tests related to today's visit?

☐ Labs ☐ X-rays ☐ CT ☐ MRI ☐ EEG ☐ ECHO ☐ Ultrasound

Where were these tests performed?

Family History (PGF/PGM = paternal grandfather/mother, MGF/MGM = maternal grandfather/mother) **Please mark all that apply**

Relationship to Patient	Age	Height	Weight	Diabetes	Thyroid	High Blood Pressure	High Cholesterol/ Triglycerides	Autoimmune disorders (Rheumatoid Arthritis, MS, Lupus, ?)
Mother								
Father								
Brother/Sister								
Brother/Sister								
Brother/Sister								
Brother/Sister								
PGM								
PGF								
MGM								
MGF								

Please indicate if there are any of the following problems in the family and who has them:

Severe Acne:	Infertility:	Irregular Periods:
Cancer:	Adrenal Insufficiency:	Menopause <40 yrs:
Excess Facial/Body Hair:	Other (explain):	

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Patient past Medical History

Prenatal (Mother's pregnancy history for the child being seen today)

Medicines used during pregnancy: _____

Complications (circle): vaginal bleeding | infection | gestational diabetes | high blood pressure | Thyroid problems

Other:

_____

Labor and Delivery: (please circle) Induced | Spontaneous Vaginal | Cesarean Section Premature | On time | Late

Complications: ☐ Yes☐ ☐ No If yes, explain: _____

Immediate Newborn Period:

Birth Weight: _____ Length: _____ Gestational age: _____ weeks

Circle any problems experienced: Jaundice | Cyanosis (blue) | Hypoglycemia (low blood sugar) | Need Oxygen |

Heart Problems | Feeding problems | other:

_____ _____

Growth and Development: (for child being evaluated)

Did your child meet milestones on time? ☐ Yes ☐ No Developmental Therapy: PT | OT | Speech | other: _____

Would you describe your child's growth as (circle one): rapid | slow | normal

Measurements in relation to peers: large | small | tall | short Sexually developed: More| Normal| Less

Illness History: (Please list problem and child's age at the time of the problem)

Serious (pneumonia, asthma, appendicitis):

_____

Trauma:

_____

Surgeries/operations:

_____

Has your child had any of the following (circle): Head Injury | Heart Problems | Sleep Apnea |

More than 2 broken bones | Other:

Social History

Who does patient live with? ☐ Both ☐ Mom ☐ Dad ☐ Other: _____

Mother's Occupation: _____Father's Occupation: _____

Parents together? ☐ Yes ☐ No If no (circle one): Mom has custody | Dad has custody

Name of school: _____ Grade in School: _____ Achievement level: Poor | Fair | Excellent

Do you have PE in school? ☐ Yes ☐ No If yes, how many times/week _____ and for how long _____minutes

What activities do you participate in? _____

Any major changes at home, such as a new infant, divorce, etc? _____

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To be answered by the PATIENT:

Do you smoke tobacco? ☐ Yes ☐ No How many times per day?

Do you chew tobacco? ☐ Yes ☐ No How many times per day?

Do you drink alcohol? ☐ Yes ☐ No How many times per day?

Health Problems: Please mark any that you have had in the past 6-12 months:

General
- ☐ Fever
- ☐ Fainting/Dizzy spells
- ☐ Frequently tired
- ☐ Trouble sleeping
- ☐ Wakes feeling tired

Ear, Nose, Throat
- ☐ Nose bleeds
- ☐ Sinus problems
- ☐ Sore throat
- ☐ Teeth problems
- ☐ Thrush
- ☐ Dry mouth
- ☐ Chronic ear infections
- ☐ Hearing problems
- ☐ Neck swelling
- ☐ Neck pain

Eyes
- ☐ Blurry vision
- ☐ Dry eyes
- ☐ Vision change
- ☐ Wears: glasses | contacts
- ☐

Blood/Lymph
- ☐ Swollen glands
- ☐ Easy bruising

Excessive bleeding

Heart
- ☐ Chest pain with activity
- ☐ Swelling in hands/feet
- ☐ Short of breath: At rest| lying down|with walking
- ☐ Known heart murmur
- ☐ Palpitations

Lungs
- ☐ Sleep apnea
- ☐ Cough
- ☐ Wheezing
- ☐ Coughing up blood
- ☐ Snoring

Gastrointestinal
- ☐ Nausea
- ☐ Abdominal pain
- ☐ Frequent vomiting
- ☐ Excessive|Poor appetite
- ☐ Diarrhea
- ☐ Constipation

Vomiting blood

Head/Neuro
- ☐ Muscle weakness
- ☐ Headaches frequent|occasional
- ☐ Seizures

Musculoskeletal
- ☐ Joint pain
- ☐ Back pain
- ☐ Muscle aches
- ☐ Muscle weakness
- ☐ Freq. broken bones #___
- ☐ Muscle spasms

Skin/Hair
- ☐ Rashes
- ☐ Dry skin
- ☐ Excess acne
- ☐ Stretch marks
- ☐ Pale/other color changes
- ☐ Excessive hair growth
- ☐ Hair loss/thinning
- ☐

Genitourinary
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Wetting bed/self
- ☐ Difficulty with urination
- ☐ Painful urination

Hormonal
- ☐ Slow height growth
- ☐ Increased thirst
- ☐ Frequently feels: hot|cold

Allergy
- ☐ Runny nose
- ☐ Hives
- ☐ Itching

Psychiatric
- ☐ Feels sad/depressed
- ☐ ADHD

Other:_____

Females only: Periods are ☐ Regular ☐ Irregular ☐ Painful ☐ Heavy ☐ Spotting between periods
☐ Vaginal Discharge: bloody | Clear | white | yellow Date of last period:

Diet and Lifestyle: If you are concerned of your child's weight, please complete the following

Serving per day of: Fruit Juice _____ Soda _____ Gatorade _____ Sweetened Drinks _____

Milk _____ (circle) skim | 1% | 2% | Whole Has: fast food | take out _____ times a week

Typically eats school cafeteria meals _____ times per week.

Typically eats _____ home prepared meals per week.

Spends _____ hours per day being physically active.

Spends _____ hours per day on TV/Electronics game

As a parent, what worries you the most about your child's eating habits? _____

Please list what your child ate for meals and snacks in the last 24 hrs:

Breakfast _____ Snack _____

Lunch _____ Snack _____