Michigan Pediatric Endocrine & Diabetes Services
3075 Clark Rd ~ Suite 100 ~ Ypsilanti, MI 48197 ~ 734-469-4775

Endocrine Information Sheet for New Patients

Please complete this endocrine information sheet and return as soon as possible using any of the following methods: 1) attach to a portal message, 2) fax to 734-744-4471, or 3) email to info@mipeds.org.

Patient Information

Patient's name: _____ Date of Birth: _____

Reason(s) for visit: ☐short stature ☐tall stature ☐excessive weight gain ☐early puberty ☐delayed puberty ☐blood sugar concerns ☐thyroid concerns ☐other: _____

Who will be with the patient at the visit: ☐mother ☐father ☐stepfather ☐stepmother ☐legal guardian ☐grandmother ☐grandfather ☐other: _____ ☐nobody-patient alone.

(NOTE: a parent or legal guardian MUST accompany a minor patient to the new patient appointment.)

History of concern:

How long ago was the problem noticed? _____

Who was concerned? ☐physician ☐patient ☐parent ☐other _____

Briefly describe the concern: _____

_____

Were there any problems with height gain? ☐Yes ☐No ☐Too fast ☐Too slow

Were there any problems with weight gain? ☐Yes ☐No ☐Too much ☐Too little ☐Weight loss

Were any labs done previously: ☐Yes ☐No If yes, where and when? _____

Were imaging studies done: ☐Yes ☐No If yes, indicate type: ☐bone age ☐thyroid ultrasound ☐Head MRI ☐Pelvic ultrasound ☐Other: _____

Is there known family history related to the reason you are here? ☐Yes ☐ No

If yes, please describe: _____

Did you bring information for us to review? ☐Growth chart ☐Laboratory tests ☐ Imaging studies ☐ Other: _____

Prenatal/Delivery History: During mother's pregnancy with this child, did mother:

Receive prenatal care : Yes____ No____

Gain more than 25 pounds: Yes____ No____

Have severe vomiting: Yes____ No____

Take any medicines other than vitamins: Yes____ No____

Use drugs: Yes____ No____

Smoke: Yes____ No____

Drink alcohol: Yes____ No____

Have any bleeding: Yes____ No____

Have any sugar in your urine: Yes____ No____

Have high blood pressure or toxemia: Yes____ No____

Weeks of pregnancy at delivery: _____ weeks

Have a caesarian (C-section): Yes____ No____

Reason for C-section: _____

How many pregnancies for mother? _____How many living children? _____

Perinatal History:

Child's Birth Weight: _____ lbs. Birth Length: _____ inches.

In the first month of life, did this child have any of these problems?

Breathing Yes____ No____

Heart Murmur Yes____ No____

Poor Weight Gain Yes____ No____

Low Blood Sugar Yes____ No____

Bleeding Yes____ No____

Jaundice Yes____ No____

Seizure Yes____ No____

Other (Specify) _____

Was this child breast-fed? Yes____ No____

Was this child on formula? Yes____ No____

Prescriptions:

*Medications child has been on other than cold remedies and antibiotics: _____

_____

*Is this child currently taking medications? Yes____ No____

List _____

Medication Allergies _____

Food Allergies _____

Surgery:

For: _____ Date: _____ Where: _____

Hospitalizations:

For: _____ Date: _____ Where: _____

Any Broken Bones:

Location: _____ Date: _____ Treated where: _____

Since one month of age, has your child had any of the following:

If Yes, please explain and give date(s) of occurrence.

	NO	YES	
Poor weight gain	____	____	_____
Poor growth in length	____	____	_____
Poor growth in height	____	____	_____
Visual problems	____	____	_____
Seizures, fits, convulsions	____	____	_____
Fainting	____	____	_____
Headache	____	____	_____
Dizziness	____	____	_____
Sinus infection	____	____	_____
Sore throat	____	____	_____
Ear infection	____	____	_____
Bronchitis	____	____	_____
Asthma	____	____	_____
Pneumonia	____	____	_____
Hay fever	____	____	_____
Heart murmur	____	____	_____
Overdresses, always cold	____	____	_____
Underdresses, always hot	____	____	_____
Dry skin or hair	____	____	_____
Rashes	____	____	_____
Thyroid problems	____	____	_____

	NO	YES	
Trouble swallowing	____	____	_____
Birth marks	____	____	_____
Stomach-ache	____	____	_____
Vomiting	____	____	_____
Diarrhea	____	____	_____
Constipation	____	____	_____
Jaundice	____	____	_____
Bloody stools	____	____	_____
Excess urine	____	____	_____
Excess thirst	____	____	_____
Dehydration	____	____	_____
Painful urination	____	____	_____
Urine or kidney infection	____	____	_____
Bedwetting	____	____	_____
Early puberty (before 8)	____	____	_____
Delayed puberty (after 14)	____	____	_____
Painful menses	____	____	_____
Irregular menses	____	____	_____
Muscle cramps	____	____	_____
Weakness	____	____	_____
Unusual fatigue	____	____	_____
Stiff or painful joints	____	____	_____
Fractures	____	____	_____
Sleep problems	____	____	_____
School problems	____	____	_____
Anemia (low blood)	____	____	_____
Low iron	____	____	_____
Bruising	____	____	_____
Excessive bleeding cuts	____	____	_____
Cancer	____	____	_____

	NO	YES	
Eczema	____	____	_____
Depression	____	____	_____
Excessive temper tantrum	____	____	_____
Bipolar disorder	____	____	_____
Oppositional defiant	____	____	_____
disorder	____	____	_____
ADD/ADHD	____	____	_____
Others Not mentioned:	____	____	_____

Nutrition:

Does your child have a good appetite? Yes ____ No ____

Does your child have a picky appetite? Yes ____ No ____

Is your child's nutrition well balanced? Yes ____ No ____

Is your child in daycare? Yes ____ No ____ If yes, where _____

Family daycare: _____ Public daycare: _____ After school care: _____

Is your child in school? Yes ____ No ____ School:_____

Grade: _____ Grades last report card: _____

IMMEDIATE FAMILY HISTORY (mother, father, siblings)**:**

Relationship	Age	Sex	Ht	Wt	Age at puberty	Current medical conditions
_____	___	___	___	___	_____	_____
_____	___	___	___	___	_____	_____
_____	___	___	___	___	_____	_____
_____	___	___	___	___	_____	_____

EXTENDED FAMILY HISTORY (paternal):

Relationship	Height	Overweight (Y/N)	Medical conditions
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

EXTENDED FAMILY HISTORY (maternal):

Relationship	Height	Overweight (Y/N)	Medical conditions
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

In the family*, is there anyone who has had:

Diabetes Mellitus	Yes____	No____
Goiter or Thyroid problems	Yes____	No____
Need to take cortisol	Yes____	No____
Early menopause (before 40)	Yes____	No____
Early puberty	Yes____	No____
Late puberty	Yes____	No____
Delayed growth	Yes____	No____
Unusually tall or short stature	Yes____	No____

*If any of the above is checked, please make sure the family relationship is appropriately noted in “EXTENDED FAMILY HISTORY” above.

If you have specific concerns or questions you would like answered, please note here:

_____

_____

_____

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