

Medical Group

9977 Woods Drive 2nd Floor
Skokie, Illinois 60077
www.northshore.org
Phone (847) 663-8508
Fax (847) 663-8515

Demographics:

Patient's Full Name:

Date of Birth: Male Female

Father's Full Name: Country of Birth:

Mother's Full Name: Country of Birth:

If separated or divorced, who has legal custody?

Home Address:

City: State: Zip code:

Home Phone: Other Phone:

Father's Employer: Work Phone:

Mother's Employer: Work Phone:

Pediatrician Information:

Pediatrician Name:

Address:

City: State: Zip code:

Office Phone: Office Fax:

Visit Information:

What is the reason for Visit:

Who is more concerned? Parents Physician

Please explain:

Prenatal Information:

Problems/ Medications during this pregnancy:

Birth Hospital Name:

Length of Pregnancy in months: Birth Length in inches:

Birth weight: _____ lbs _____ oz Weight was more less same than other(s)

| | |
|---|---|
| Jaundice (yellow color)? <input type="checkbox"/> Yes <input type="checkbox"/> No | Treated with oxygen? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Were there any problems with the <i>Delivery</i> ? | |
| After how many days was the baby brought home? | |
| Were there any problems during the <i>first months of life</i> ? | |
| Breast-fed for _____ months | Bottle-fed for _____ months |

Early Growth and Development:

| | |
|--|--------------------|
| About how old was your child when he/she could do the following: | |
| Sit: | Ride a Tricycle: |
| Walk: | Speak first words: |
| Overall, did this child seem <input type="checkbox"/> slower, <input type="checkbox"/> faster, or <input type="checkbox"/> about the same as your other did? | |

School Information:

| | |
|---|------------------------------|
| Grade level: | Report Card grade or G.P.A.: |
| Performance: <input type="checkbox"/> As expected <input type="checkbox"/> Below expected <input type="checkbox"/> Above expected | |
| Does your child have any Learning Disabilities? | |
| Is he/she receiving any therapies? | |
| <input type="checkbox"/> OT <input type="checkbox"/> PT <input type="checkbox"/> Speech therapy <input type="checkbox"/> Tutoring in: | |

Past History:

| | |
|---|--|
| First Tooth in by age: | Lost first tooth by age: |
| Does your Child show signs of Sexual Development (Puberty) ? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| If yes, How old was your child when you first noticed the following: | |
| Body odor: | Underarm Hair: |
| Acne: | Facial Hair: |
| Pubic Hair: | <i>Sexual characteristics (see below)</i> |
| <i>Girls</i> | <i>Boys</i> |
| Breast budding or tenderness: | Growth of penis or Testicles: |
| First bleeding period: | Voice deepening: |

Does your child have concerns with any of the following: (please give details below)

| | | |
|--|--|--|
| Dark or Pale skin spots or birthmarks: | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Headaches, seizures, or loss of consciousness: | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Broken bones or head injuries: | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Vision: | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Hearing loss or ear infections: | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Sense of smell | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Eating (swallowing, appetite) | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Heart or blood pressure: | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Asthma: | <input type="checkbox"/> Yes <input type="checkbox"/> No | |

| | | |
|--|--|--|
| Digestive (constipation, vomiting, stomach aches, diarrhea): | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Nervous /Emotional Disorder; | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Bladder or Kidney: | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Weakness: | <input type="checkbox"/> Yes <input type="checkbox"/> No | |

Allergies and Medication:

| |
|--|
| Drug Allergies: |
| What Happened in the allergic reaction: |
| What medicines, irons, or vitamins does your child take? |

Hospitalization:

| | | |
|--|--------------|------------|
| Was your Child Hospitalized overnight? <input type="checkbox"/> Yes <input type="checkbox"/> No (if yes, please fill out the boxes below.) | | |
| <i>Which (year)</i> | <i>Where</i> | <i>Why</i> |
| | | |
| | | |
| | | |

Family History: *(Please use extra paper if needed; Give names of children)*

| | Age | Height | Puberty | Health issues |
|--------|-----|--------|--------------------------------------|---------------|
| Father | | | He reached final height at yrs | |
| Mother | | | Her first menstrual period at yrs | |
| Child: | | | | |
| Child: | | | | |
| Child: | | | | |

The rest of the family: Does anyone on either side of the family have a medical problem with anything listed below? Be sure to tell us whom (for example: mother's grandfather)

| | | |
|-------------------------------|--|--|
| Diabetes: | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Thyroid (or goiter): | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Unusually short: | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Puberty (early or late): | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Adrenal hormone problems: | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Rickets: | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Unable to have children: | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| High or low calcium problems: | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Mental or Brain Retardation: | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Child died early: | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Tumor in Childhood: | <input type="checkbox"/> Yes <input type="checkbox"/> No | |

| | | |
|--|--|--|
| High Cholesterol: | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| High blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Heart attack or stroke before age 55 years | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Any marriage between relatives? | <input type="checkbox"/> Yes <input type="checkbox"/> No | |

The family social history.

| | |
|---|----------------------|
| Who is the primary caretaker? | |
| Mother's Occupation: | Father's Occupation: |
| Known stresses (e.g., deaths, illnesses, social): | |
| | |

Other:

Is there any other information that you would like to let us know:

IF YOUR CHILD HAS A PROBLEM WITH HEIGHT OR WEIGHT, THEN **BRING ALL GROWTH RECORDS** FROM HOME, SCHOOL, AND YOUR DOCTOR.

Return this form to:

Address: Pediatric Endocrinology 9977 Woods Drive, Skokie, IL 60077

Phone: 847.663.8508

Fax: 847.663.8515

Please note: appointments cancelled and/or rescheduled less than 24 business hours in advance will result in a **\$50.00** charge.