

**Medical Group**

9977 Woods Drive 2<sup>nd</sup> 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 <b>Sexual Development ( Puberty)</b> ? <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.