NorthShore
University HealthSystem

Medical Group

Pediatric Endocrinology and Diabetes

9977 Woods Drive
Skokie, Illinois 60077
www.northshore.org/pedsendo

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)? [ ]Yes [ ]No	Treated with oxygen? [ ]Yes [ ]No
Were there any problems with the *Delivery*?	
After how many days was the baby brought home?	
Were there any problems during the *first months of life*?	
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 [ ]slower, [ ]faster, or [ ]about the same as your other(s) did?	

School Information: Grade level:	Report Card grade or G.P.A:
Performance: [ ]As expected [ ]Below expected [ ]Above expected	
Does your child have any Learning Disabilities?	
Is he/she receiving any therapies? [ ]OT [ ]PT [ ]Speech therapy [ ]Tutoring in:	

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

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

Dark or Pale skin spots or birthmarks:	[ ]Yes [ ]No	
Headaches, seizures, or loss of consciousness:	[ ]Yes [ ]No	
Broken bones or head injuries:	[ ]Yes [ ]No	

Vision:	[ ]Yes [ ]No	
Hearing loss or ear infections:	[ ]Yes [ ]No	
Sense of smell	[ ]Yes [ ]No	
Eating (swallowing, appetite)	[ ]Yes [ ]No	
Heart or blood pressure:	[ ]Yes [ ]No	
Asthma:	[ ]Yes [ ]No	

Medication and Allergies:
What **medicines**, vitamins, or supplements does your child take?

Drug Allergies:

What Happened in the allergic reaction:

Hospitalization:
Was your child hospitalized overnight? [ ]Yes [ ]No (if yes, please fill out the boxes below.)

Which (year)	*Where*	*Why*

Surgeries:

Year	*Type*

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:	[ ]Yes [ ]No	
Thyroid (or goiter):	[ ]Yes [ ]No	
Unusually short:	[ ]Yes [ ]No	
Puberty (early or late):	[ ]Yes [ ]No	
Adrenal hormone problems:	[ ]Yes [ ]No	
Rickets:	[ ]Yes [ ]No	

Unable to have children:	[ ]Yes [ ]No	
High or low calcium problems:	[ ]Yes [ ]No	
Intellectual Disability:	[ ]Yes [ ]No	
Child died early:	[ ]Yes [ ]No	
Tumor in Childhood:	[ ]Yes [ ]No	
High Cholesterol:	[ ]Yes [ ]No	
High blood Pressure	[ ]Yes [ ]No	
Heart attack or stroke before age 55 years	[ ]Yes [ ]No	
Any marriage between relatives?	[ ]Yes [ ]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.