NorthShore University HealthSystem

Medical Group

Pediatric Endocrinology and Diabetes
Dr. Drobac New Patient Form

Patient Information	
Patient's Name:	Patient's Date of Birth:
Age when concern started:	Referred by [Physician Name]:
Were any tests, labs or x-rays completed related to today's visit? [ ] Yes [ ]No If so, where were they performed? When?	
Has your child been seen by an endocrinologist previously? [ ] No [ ]Yes, When?	
Did your child's primary physician recommend this visit? [ ] Yes [ ] No	
Main reason for the visit today?	

Parent/Guardian Information	
Parent One Name: Parent One Occupation:	Best Contact Number:
Parent Two Name: Parent Two Occupation:	Best Contact Number:
Patient Primary Home Address:	
City/State:	Zip Code:

Custody
Parents are: [ ]Married [ ]Separated [ ]Divorced
If divorced or separated, who has legal custody?
Are any of the parents restricted (must provide legal paperwork) from being included or provided medical information about the patient? [ ] Yes [ ]No

Pediatrician Information		
Physician's Name:		
Phone:	Fax if known:	
Address:	City/State:	Zip code:

School Information	
Grade level:	
Any learning difficulties [ ]No [ ]Yes, Please explain:	Therapies child is receiving: [ ]OT [ ]PT [[ ]Speech therapy [ ]Tutoring in:
Performance: [ ]As expected [ ]Below expected [ ]Above expected	
Birth Information	
Were there any concerns during pregnancy? [ ]No [ ]Yes, please list below	
Full term [ ]Yes [ ]No, # of weeks _____	[ ]Child adopted, history not known
Birth weight: _____ lbs. _____ oz.	Birth length: _____ inches
Any problems during delivery? [ ]No [ ]Yes If Yes, explain:	
Did the child go to the ICU? [ ]No [ ]Yes	If yes, how many days and reason:
[ ]Breast milk [ ]Formula [ ]Special formula	Diet/weight concerns? [ ]No [ ]Yes
Did your child have any developmental delays? [ ] No [ ]Yes, please list:	
Medical History	
Please list current medications, vitamins or supplements that your child takes: Name: Dose: Name: Dose: Name: Dose: Name: Dose: Name: Dose:	
Does your child have any drug allergies? [ ] No [ ]Yes Drug name: Reaction:	
Medical Conditions	
Please list any medical conditions your child has: 1. 2. 3. 4.	
Surgeries [ ]No [ ]Yes list below:	
Year	**Type of Surgery**

Pubertal Changes		
Does your child show signs of Sexual Development (Puberty)? [ ]Yes [ ]No		
If yes, at what age did you first notice the following in your child? (List age)		
Body odor _____years old	Underarm Hair _____years old	Acne _____years old
Facial hair _____years old	Pubic hair _____years old	

Female Patients	
Breast budding/tenderness _____years old	First bleeding period _____years old

Male Patients	
Growth of penis or testicles _____years old	Voice deepening _____years old

All Patients - Other Medical Concerns		
Does your child have any of the following? (Please provide details below):		
Fatigue or low energy?	[ ]Yes [ ]No	Details:
Eating or appetite concerns?	[ ]Yes [ ]No	Details:
Recent weight gain or loss?	[ ]Yes [ ]No	Details:
Vision or hearing problems?	[ ]Yes [ ]No	Details:
Acne/ Extra facial or body hair/ Hair loss?	[ ]Yes [ ]No	Details:
Respiratory or heart problems?	[ ]Yes [ ]No	Details:
Gastrointestinal concerns? (Constipation, diarrhea, abdominal pain, vomiting)	[ ]Yes [ ]No	Details:
Increased thirst or frequent urination?	[ ]Yes [ ]No	Details:
Headaches or seizures?	[ ]Yes [ ]No	Details:
Joint pain or broken bones?	[ ]Yes [ ]No	Details:
Any other concerns:		Details:

Relevant Family History			
[ ]**Section not applicable –** family history is not known for child			
	Age	**Height**	**Puberty**
Father			Reached final height at ___yrs.
Mother			First Period at ____ yrs.
Sibling:			
Sibling:			
Sibling:			
Sibling:			
Sibling:			

Does anyone on either side of the family have a medical problem with anything listed below?	**Choose (yes or no)**	**List relationship (i.e., brother, sister, mother, father, grandparent, cousin)**
Diabetes	[ ]Yes [ ]No	
Thyroid problem	[ ]Yes [ ]No	
Short stature	[ ]Yes [ ]No	
Late or early puberty	[ ]Yes [ ]No	
Adrenal hormone problem	[ ]Yes [ ]No	
Polycystic ovary syndrome (PCOS)	[ ]Yes [ ]No	
High or low calcium problems	[ ]Yes [ ]No	
GI disorders (Celiac, Crohn's)	[ ]Yes [ ]No	
Elevated cholesterol	[ ]Yes [ ]No	
Heart attack or stroke before 55 yrs.	[ ]Yes [ ]No	

Other Information
Please list any other information that you feel is important for us to know:

Please return this form by fax to 847.663.8515, attach to NorthShoreConnect or bring completed to your office visit.

Please Note**:** Appointments cancelled and/or rescheduled less than 24 business hours in advance will incur a late cancellation fee of **$100.00**. Thank you! We look forward to meeting you and your child.