PennState Health
Milton S. Hershey Medical Center

PEDIATRIC ENDOCRINOLOGY NEW PATIENT QUESTIONNAIRE

Patient Name:____________________

Date of Birth:____________________ Age:__________

What is the reason for your child's visit today? ____________________

____

Birth History: Birth weight:________lbs. ________oz. Birth length:________inches

Full term: ☐ Yes ☐ No Gestational age:____________

Problems with the pregnancy? ☐ Yes ☐ No Explain: ____________________

Problems in the nursery? ☐ Yes ☐ No Explain: ____________________

Medical History: Please check if your child has or has had any of the following:

PAST	CURRENT	
☐	☐	headaches or head injury
☐	☐	eye or vision problems
☐	☐	bulging eyes
☐	☐	ear infections
☐	☐	hearing problems
☐	☐	nose problems, allergies or snoring
☐	☐	sore throat or hoarseness
☐	☐	shortness of breath
☐	☐	asthma
☐	☐	cough
☐	☐	heart abnormality
☐	☐	heart murmur
☐	☐	heart beat racing
☐	☐	swelling of the hands, feet or face
☐	☐	poor appetite
☐	☐	increased apetite
☐	☐	vomiting
☐	☐	reflux
☐	☐	abdominal pain
☐	☐	diarrhea
☐	☐	constipation
☐	☐	bloody stools
☐	☐	kidney or bladder infections
☐	☐	kidney stones
☐	☐	excessive urination
☐	☐	excessive thirst
☐	☐	menstrual abnormalities
☐	☐	date of last period
☐	☐	abnormalities of the penis
☐	☐	pain or swelling of the joints
☐	☐	bone deformities
☐	☐	fractures
☐	☐	muscle weakness

PAST	CURRENT	
☐	☐	early puberty
☐	☐	late puberty
☐	☐	slow growth
☐	☐	rapid growth
☐	☐	weight loss
☐	☐	weight gain
☐	☐	easily tired
☐	☐	hair loss
☐	☐	always cold
☐	☐	always hot
☐	☐	breast discharge
☐	☐	seizures
☐	☐	fainting or dizziness
☐	☐	uncoordinated
☐	☐	attention problems
☐	☐	difficulty concentrating
☐	☐	learning disability
☐	☐	school problems
☐	☐	delay in normal developement
☐	☐	behavior changes
☐	☐	skin rash
☐	☐	birthmarks or moles
☐	☐	dry skin
☐	☐	excessive sweating
☐	☐	excess body hair
☐	☐	dark areas on the skin
☐	☐	admitted to hospital
☐	☐	had surgery
☐	☐	taking medications
☐	☐	allergies to medications, food, etc.

PennState Health
Milton S. Hershey Medical Center

MUST HAVE AN OOS LABEL ON THE FRONT SIDE OF THIS FORM
(2-SIDED FORMS MUST HAVE AN OOS LABEL ON BOTH SIDES)

PEDIATRIC ENDOCRINOLOGY NEW PATIENT QUESTIONNAIRE

Please complete the following chart for your family members:

Family History: Please check all that apply

Relative	Height	Weight	Age of puberty of first period	Any growth problems?	Diabetes	Thyroid Disease	Adrenal Disease	Infant Death	Other
Mother									
Father									
Maternal Grandmother									
Maternal Grandfather									
Paternal Grandmother									
Paternal Grandfather									
Siblings - list below brother or sister & age									
1.									
2.									
3.									
4.									

Any other information you with the doctor to know about your child:

____

____

____

____

____

PLEASE BRING THIS FORM TO YOUR CHILD'S DOCTOR APPOINTMENT.

Thank you.

Name of person completing this form: ______________________________

Relationship to patient: ______________________________

Reviewed by: ________________________ ________________

Signature *Date/Time*