PEDIATRIC ENDOCRINOLOGY CLINIC QUESTIONNAIRE

The Division of Pediatric Endocrinology at Palo Alto Medical Foundation evaluates conditions and disorders of hormones derived from endocrine glands. We treat children with various problems including growth difficulty, growth hormone, thyroid or adrenal abnormalities. In order to make your appointment as efficient and complete as possible, please fill out this questionnaire and bring it with you at the time of your appointment.

REFERRAL INFORMATION:
Self referred □ or Referred by: □_____________________________________________________________ Phone: ____________________________

Provider address if other than PAMF:_____________________________________ Phone:________________________

Would you like a report of your visit sent to your Referring Doctor?  Y □  N  □

REASON FOR EVALUATION:
What is the main reason you are bringing your child to the Endocrinology Clinic? ______________________________
________________________________________________________________________________________________
________________________________________________________________________________________________
________________________________________________________________________________________________

Family Concern □  Physician Concern □  Both

Do you have any concerns that you would rather discuss when your child is not in the examination room? ____________
________________________________________________________________________________________________
________________________________________________________________________________________________
________________________________________________________________________________________________

When was the problem that you are coming in for first noticed?______________________________________________
________________________________________________________________________________________________

Has any other evaluation been performed, and if so, where?_________________________________________________
________________________________________________________________________________________________

• If yes, please request medical records be sent to our clinic. You may also bring them to your appointment. Many endocrine conditions involve alterations in growth rate. It is extremely valuable to us if you contact all previous physicians that have cared for your child and have them send height and weight measurements with the dates that they were performed, ask for a growth chart. Any lab work or imaging that your child has done should also be requested. (Please disregard if your child is an established patient at PAMF and you have previously submitted supporting documentation).
BIRTH HISTORY:
Age of parents at birth:  Mother _____________ Father _____________ AND/OR Child’s age at adoption: ____________
Mother’s health during pregnancy:  ☐ Diabetes, ☐ High Blood Pressure, ☐ Infections, ☐ Fevers, ☐ Other: __________
Was the pregnancy:  ☐ full term ☐ premature ____________ weeks ☐ overdue ____________ weeks
Was the delivery:  ☐ spontaneous ☐ c-section
Medications taken during pregnancy: ___________________________________________________________________
Were there any complications during the pregnancy?  Y ☐  N ☐
If YES, please explain: ________________________________________________________________________________
__________________________________________________________________________________________________

EARLY MEDICAL DATA:
What was the birth weight?  _________ What was the birth length?  ________ Length of stay in hospital?  ____________
Jaundiced? ___________________________________ Low blood sugar?  ______________________________________
Were there any complications after birth?  Y ☐  N ☐
If YES, please explain: ________________________________________________________________________________
__________________________________________________________________________________________________

PATIENT’S MEDICAL HISTORY:
Does anyone in your household smoke, and if so, who?  ____________________________________________________
Please check any medical conditions which apply to your child, and the age when they began:

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<thead>
<tr>
<th>Condition</th>
<th>Y / N</th>
<th>Age</th>
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<tbody>
<tr>
<td>Acne/Extra Facial Hair</td>
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<td>Allergies</td>
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<td>Asthma</td>
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<td>Diabetes</td>
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<td>Diarrhea/Constipation</td>
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<tr>
<td>Dizziness</td>
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<tr>
<td>Eating problems</td>
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<tr>
<td>Excessive Thirst</td>
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<td>Frequent Urination</td>
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<tr>
<td>Heart Problems</td>
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</tbody>
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<tr>
<th>Condition</th>
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<tbody>
<tr>
<td>Headaches</td>
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<td>High Blood Pressure</td>
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<td>Learning Disabilities</td>
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<td>Hyperactivity</td>
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<td>Seizures</td>
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<td>Low Blood Pressure</td>
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<td>Vision Problems</td>
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<tr>
<td>Stomach Cramps/Bloating</td>
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<td>Weight Loss/Gain</td>
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<td>Visual Problems</td>
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Other Conditions: ____________________________________________________________________________________

Current Medications: ________________________________________________________________________________

Allergies: __________________________________________________________________________________________

__________________________________________________________________________________________________
FAMILY INFORMATION:

Child lives with: □ Biological Mother, □ Adoptive Mother, □ Stepmother, □ Other ___________________________

Name: ________________________________________________ Phone: ______________________________________

Biological mother’s present height: __________ Present weight: __________ Age at first menstrual period: __________

Early or late bloomer? ______________________________________________________________________________

Child lives with: □ Biological Father, □ Adoptive Father, □ Stepfather, □ Other ___________________________

Name: ________________________________________________ Phone: ______________________________________

Biological father’s present height: __________ Present weight: __________ Age when started shaving: __________

Age when stopped growing: __________ Early or late bloomer? ______________________________________________________________________________

FAMILY MEDICAL HISTORY:

Does anyone in your family have/had the following health conditions and if so, who:

Autoimmune Disorders (Celiac, Crohn’s, Lupus): ___________________________________________________________

Diabetes requiring insulin _____________________________________________________________________________

Diabetes treated with oral medication ___________________________________________________________________

Elevated Cholesterol/Lipids _____________________________________________________________________________

Hypothyroid _______________________________________________________________________________________

Hyperthyroid _______________________________________________________________________________________

Other thyroid problems ______________________________________________________________________________

Growth Issues ______________________________________________________________________________________

Heart attack/Stroke __________________________________________________________________________________

If yes, did the incidence occur under the age of 55 for men or under 65 for women? _________________________

Irregular menses/PCOS _______________________________________________________________________________

Infertility problems __________________________________________________________________________________

Other chronic illnesses ______________________________________________________________________________

DEVELOPMENTAL HISTORY:

Age child: sat alone __________ crawled __________ stood alone __________ walked alone __________

talked in sentences __________ toilet trained __________ first tooth __________ first permanent tooth __________

SCHOOL:

Current grade level: __________ School performance: ______________________________________________________

PHYSICAL ACTIVITY:

Does your child participate in regular physical activity? Y □ N □

If yes, what type of physical activity? __________________________________________________________________

How many times a week? ______________________________________________________________________________
PHARMACY:
Preferred local pharmacy: ____________________________________________________________________________
Preferred mail order pharmacy: ________________________________________________________________________

FAMILY CONTACT INFORMATION:

Please tell us the best way to contact you if we need to reach you regarding any medical issues.
Home: ____________________________________________________________________________________________
Cell: ______________________________________________________________________________________________
Work: _____________________________________________________________________________________________

Can we leave detailed message pertaining medical information on your voicemail?  ☐ Y  ☐ N
Would you like to be contacted using My Health Online?  ☐ Y  ☐ N

Name of person completing questionnaire: _______________________________________________________________
Relationship to patient: _____________________________________________________________________________

Your Child’s is scheduled for an appointment with:

Dr. Diane Suchet  Dr. Sayali Ranadive  Dr. Matt Stenerson

Date: ____________________________  Time: ____________________________

Location:
☐ DUBLIN:  4050 Dublin Boulevard, Pediatrics, PH: 925-875-6100
☐ FREMONT:  3200 Kearney Street, 1st Floor Pediatrics, PH: 510-490-1222
☐ LOS ALTOS:  370 Distel Circle, South Side of building, PH: 650-254-5200
☐ PALO ALTO:  795 El Camino Real, 1st Floor Pediatrics, PH: 650-853-2992
☐ MOUNTAIN VIEW:  701 E. El Camino Real, Pediatrics, PH: 650-934-7956

**Please call the office at least 24 hours in advance if you’re unable to keep your appointment.