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: ☐ ____

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? ________________________________

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☐ Family Concern ☐ Physician Concern ☐ Both

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

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____

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 altercations 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 documentatio*n).

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:

Condition	Y / N	Age
Acne/Extra Facial Hair		
Allergies		
Asthma		
Diabetes		
Diarrhea/Constipation		
Dizziness		
Eating problems		
Excessive Thirst		
Frequent Urination		
Heart Problems		

Condition	Y / N	Age
Headaches		
High Blood Pressure		
Learning Disabilities		
Hyperactivity		
Seizures		
Low Blood Pressure		
Vision Problems		
Stomach Cramps/Bloating		
Weight Loss/Gain		
Visual Problems		

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.**