Pediatric Endocrinology
New Patient Intake Form

PROVIDENCE Children's Health

Appointment Date: _____ **Patient Name**_____

Patient's preferred name: _____ **Date of birth:** _____

Gender at birth: □ **Male** □ **Female** **Gender identity:** □ **Male** □ **Female** □ **Other:** _____

Preferred Language: _____ **Would you like an interpreter?** ____

Who is here today with the patient? _____

Name of referring or primary care doctor: _____

For Clinic Use	
Height (cm)	
Weight (kg)	

What matters to you today?

_____

Birth History

Gestational age: □ Full term □ Premature by _____ weeks

Birth weight: _____ Birth length: _____ Length of stay in the nursery or NICU: _____

Any health problems during or after delivery, or before age 1 year? _____

If so, please describe: _____

Other known medical conditions □ **NONE**

_____

_____

Past Surgeries □ **NONE**

_____

Past Hospital Stays □ **NONE**

_____

Current Medications □ **NONE**

Medication, supplements, vitamins and herbs. Please include amount and how many times a day.

_____

_____

Medication Allergies and Side Effects □ **NONE**

Medication	Allergic reaction or side effect
_____	_____

Immunizations up to date	Development or Behavioral Concerns? Please include any special services.
□ Yes □ No	□ Yes □ No. If yes, please describe:

PLEASE FILL OUT THE BACK OF THIS FORM.

Problems that you have on a regular bases or are going on right now. □ **NONE**

□ Low energy or fatigue	□ High blood pressure	□ Body odor or acne
□ Sleep problems or snoring	□ Frequent diarrhea	□ Excess hair or hair loss
□ Change in appetite	□ Constipation	□ Increased thirst or urination
□ Change in weight	□ Belly pain	□ Wetting or urine accidents
□ Change in vision	□ Kidney or bladder infection	□ Changes in behavior
□ Glasses or contacts	□ Joint swelling or pain	□ Depression
□ Dental problems	□ Seizures	□ Anxiety
□ Late eruption of teeth	□ Headaches	□ Easy bruising or bleeding
□ Ear infections	□ Head injury	□ Environmental allergies
□ Has nosebleeds often	□ Early or late puberty	
□ Asthma or wheezing	□ Age of first period, if applicable	
□ Heart problems	□ Irregular menstrual periods	

Family History

Relationship (circle please)	Name	Age	Height	Weight	Age of first menstrual period (if applicable)	Parent's occupation and name of employer
Parent (M/F)						
Parent (M/F)						
Sister/brother						
Sister/brother						
Sister/brother						

Using the abbreviations below, note any family history of the following health conditions:

M = Mother F= Father S = Sister B= Brother
MGM = Maternal Grandmother MGF = Maternal Grandfather
PGM = Paternal Grandmother PGF = Paternal Grandfather

Condition	**Family Member**	**Condition**	**Family Member**
□ Diabetes	_____	□ Heart disease	_____
□ Thyroid problems	_____	□ Cancer	_____
□ Menstrual issues	_____	□ Short stature	_____
□ High cholesterol	_____	□ Early or late puberty	_____
□ Autoimmune condition	_____	□ Obesity	_____
□ Celiac Disease	_____	□ Bone disease	_____
□ High blood pressure	_____	□ Other	_____

Social History

Who lives with the patient? _____
Parents' marital status: (circle one) : single married separated divorced other
Who cares for the patient during the day? _____
School: _____ Grade in school: _____
Academic performance: □ Above average □ Average □ Below Average
Activities, hobbies or sports: _____
Type of pets or animals at home: □ None _____ _____
Other social concerns (stresses, divorce, custody, abuse, etc.): _____

Is there anything else you would like the doctor to know about you? _____
Name and location of your pharmacy: _____