Pediatric Endocrinology
Follow Up Intake Form

PROVIDENCE Children's Health

Appointment Date: _____ **Patient Name_____**

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

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

Who is here today with the patient? _____

Send records my PCP (name): _____ **Other provider(s):_____**

CLINIC USE ONLY		
	Previous Visit	**Today's Visit**
Date		
Height (cm)		
Weight kg)		

Your MAIN symptom is:	
What matters to you today?	
How have your symptoms or health condition changed since your last visit?	
Since your last visit with us, have you:	
Been in the hospital overnight?	□ No □ Yes:
Had surgery?	□ No □ Yes:
Had any major illnesses or injuries?	□ No □ Yes:
Had any medical tests done?	□ No □ Yes:
Had a family member diagnosed with a new health problem?	□ No □ Yes:

Any changes to your medications, including vitamins or supplements □ No □ Yes: _____

Any new allergies? □ No □ Yes: _____

Other symptoms since your last visit: □ NONE

□ Appetite change	□ Feeling too hot or too cold	□ Skin dryness or changes
□ Unusual tiredness	□ Belly pain	□ Hair loss
□ Headaches	□ Constipation	□ Increased thirst or urination
□ Breathing issues	□ Frequent diarrhea	□ Wetting or urine accidents
□ Sleep problems or snoring	□ Joint or muscle pain	□ Behavior change
□ Fast heart rate	□ Puberty changes	□ Anxiety
□ Chest pain	□ Irregular menstrual periods	□ Depression

Social History	
Any changes with who lives at home with the patient?	□ No □ Yes:
Any changes in the parents' marital status?	□ No □ Yes:
Any changes in parents' employment?	□ No □ Yes:
Any plans to move?	□ No □ Yes: Where? When?
Grade in school:	Any concerns in school □ No □Yes:
Sports/ Regular exercise?	□ No □ Yes:

Do you have prescriptions that need to be refilled? □ No □ Yes: _____

Name and location of your preferred pharmacy: _________

Phone number for our office to reach you: _____