Pediatric Endocrinology of New York PC

Pregnancy and New Born History

Did you carry your child for the full 9 months? ☐ Yes ☐ No
If no, how many weeks? Early Late
Child's birth weight? _____Lbs. _____ Oz Height _____ In
Medication during pregnancy? _____
Problems during pregnancy:
☐ Illnesses
☐ Infections
☐ Bleeding
☐ Morning Sickness
☐ None
☐ Other

Delivery: Vaginal C section (why) _____
Any difficulties? ☐ Yes ☐ No
Any breathing problems at birth? ☐ Yes ☐ No
Did your child have "yellow" jaundice? ☐ Yes ☐ No
Did the child come home from the hospital with you? ☐ Yes ☐ No
Was you child: ☐ Bottle Fed or ☐ Breast Fed?

Development

Was your child's development normal? _____

Any serious or chronic illness during childhood? _____

Any serious falls or injuries, including any broken bones? _____

Any hospitalization for illness or evaluation of a medical (non-surgical) problem? (Also give hospital and child's age): _____

Any operations? (Give hospital and child's age): _____

Is your child on any medication? If yes, what are they? _____

Known allergies: _____

Has your child ever complained of or been seen by a physician for any of the following?

Dizziness	Feeding Problems	Painful Urination
Hearing Problems	Abnormal Periods	Seizures or convulsions
Frequent Colds	Difficulty tolerating cold	Hyperactivity
Heart Murmur	Abnormal weight loss or gain	Blurred Vision
Frequent Vomiting	Frequent sore throats	Asthma
Frequent Urination	Urine Infections	Undescended Testicles
Hernias	Weakness of Muscles	Fainting Spells
Skin Problems	Difficulty Tolerating Heat	Anemia
Chronic Fatigue	Psychological Problem	Sleeping Problem
Tingling or numbness in hand or feet	High Cholesterol	Headache
Frequent Constipation	Ear Infections	Pneumonia

Family History

Please give the birthdate, age, weight, current health and if female, age of first menstrual period, of the following family members:

Family Member	Age	Height	Current Health	If female, 1st Period
Father				
Mother				
Patient's Brothers				
Patient's Sisters				

Do any of these problems run in your family? (Indicate mother's or father's side)

Diabetes (sugar)	Thyroid Problems	Heart Disease
High Cholesterol	High Blood Pressure	Low Blood Sugar

Are there any emotional problems related to your child's medical reason for seeing us? (Use additional sheet if necessary) _____

Is there any information we should be aware of? _____