Endocrine Information Sheet

Please complete this endocrine information sheet and bring to your child's appointment.

Date: _____ Child's Name:_____
Date of Birth: _____ Age: _____Race/Sex_____
Address:_____
City: _____State: _____ Zip Code: _____
Home Phone #(s): (___)_____ Cell Phone #(s): (___)_____
Other Phone #(s): (___)_____ Email Address: _____
Childs's Present Primary Care Doctor:
Name:_____
Address: _____
City/State/Zip:_____
Phone#: (___) _____

Family Members:
Mother: _____ Occupation: _____Work #: _____
Father: _____ Occupation: _____ Work #: _____
Step-Father: _____ Occupation: _____ Work #: _____
Step-Mother: _____ Occupation: _____ Work #: _____

List all individuals living in the home:
1) _____/_____ 4) _____/_____
2) _____/_____ 5)_____/_____
3) _____/_____ 6)_____/_____

Are parents of this child: Single____ Married ____ Separated ____ Divorced____
Mother remarried _____ Father remarried _____

With whom does this child live? _____

Water Supply: City _____ Well _____

Prenatal/Delivery History: During your pregnancy with this child did you:
Receive prenatal care yes ____ no ____
Gain more than 25 pounds yes ____ no ____

Have severe vomiting	yes ____	no ____
Take any medicines other than vitamins	yes ____	no ____
Use drugs	yes ____	no ____
Smoke	yes ____	no ____
Use Alcohol	yes ____	no ____
Have any bleeding	yes ____	no ____
Have any sugar in your urine	yes ____	no ____
Have high blood pressure or toxemia	yes ____	no ____
Weeks of Pregnancy at delivery	_____weeks	
Have a caesarian (C-section)	yes ____	no ____

Reason for C-section: _____

How many times have you been pregnant? _____

How many living children do you have? _____

Perinatal History:

Child's Birth Weight: _____ lbs. Birth Length: _____ inches.

In the first month of life did this child have any of these problems?

Breathing	yes _____	no _____
Heart Murmur	yes _____	no _____
Poor Weight Gain	Yes _____	no _____
Low Blood Sugar	yes _____	no _____
Bleeding	yes _____	no _____
Jaundice	yes _____	no _____
Seizure	yes _____	no _____

Other (specify) _____

Was this child breast-fed? yes _____ no _____

Was this child on formula? Yes _____ no _____

Prescriptions:

* Medications that this child has been on other than cold remedies and antibiotics: _____

* Is this child currently taking medications? Yes _____ no _____

List_____

Medication allergies_____

Surgery:

For: _____ Date: _____ Where: _____

Hospitalizations:
For: _____ Date: _____ Where: _____
Any Broken Bones:
Location: _____ Date: _____ Treated where: _____
Allergies to Food / Medicines: _____

Since one month of age, has your child had any of the following:

	NO	YES	If yes, please explain. (Dates of the Occurrence and if it is still present)
Poor weight gain	_____	_____	_____
Poor growth in length	_____	_____	_____
Poor growth in Height	_____	_____	_____
Visual problems	_____	_____	_____
Seizures, Fits, Convulsions	_____	_____	_____
Fainting	_____	_____	_____
Headache	_____	_____	_____
Dizziness	_____	_____	_____
Sinus Infection	_____	_____	_____
Sore Throat	_____	_____	_____
Ear Infections	_____	_____	_____
Bronchitis	_____	_____	_____
Asthma	_____	_____	_____
Pneumonia	_____	_____	_____
Hay Fever	_____	_____	_____
Heart Murmur	_____	_____	_____
Overdresses, always cold	_____	_____	_____
Underdresses, always hot	_____	_____	_____
Dry skin or hair	_____	_____	_____
Rashes	_____	_____	_____
Thyroid Problems	_____	_____	_____
Trouble Swallowing	_____	_____	_____
Stomach Ache	_____	_____	_____
Vomiting	_____	_____	_____

Diarrhea	_____	_____	_____
Constipation	_____	_____	_____
Jaundice	_____	_____	_____
Bloody stools	_____	_____	_____
Excess Urine	_____	_____	_____
Excess thirst	_____	_____	_____
Dehydration	_____	_____	_____
Painful Urination	_____	_____	_____
Urine or kidney infection	_____	_____	_____
Bedwetting	_____	_____	_____
Early puberty (before age 8)	_____	_____	_____
Delayed puberty (after age 14)	_____	_____	_____
Painful menses	_____	_____	_____
Irregular menses	_____	_____	_____
Muscle cramps	_____	_____	_____
Weakness	_____	_____	_____
Unusual fatigue	_____	_____	_____
Stiff or painful joints	_____	_____	_____
Fractures	_____	_____	_____
Sleep Problems	_____	_____	_____
School Problems	_____	_____	_____
Anemia (low blood)	_____	_____	_____
Low Iron	_____	_____	_____
Bruising	_____	_____	_____
Excessive bleeding cuts	_____	_____	_____
Cancer	_____	_____	_____
Eczema	_____	_____	_____
Birth Marks	_____	_____	_____
Depression	_____	_____	_____
Excessive Temper Tantrums	_____	_____	_____
Bipolar Disorder	_____	_____	_____
Oppositional Defiant Disorder	_____	_____	_____
Attention Deficit Disorder	_____	_____	_____
Attention Deficit/Hyperactive	_____	_____	_____

Others not mentioned on previous page:_____

_____

Nutrition:

Does your child have a good appetite? Yes _____ no _____
Does your child have a picky appetite? Yes _____ no _____
Is your child's nutrition well balanced? Yes _____ no _____
Is your child in daycare? No _____ yes _____ where? _____
Family daycare: _____ Public daycare: _____ After school care: _____
Is your child in school? No _____ yes _____ school: _____
Grade: _____ Grades last report card: _____

FAMILY HISTORY:	Age	sex	height	weight	age at puberty period/shaving	Current medical conditions
Father	___	___	_____	_____	_____	_____
Mother	___	___	_____	_____	_____	_____
Siblings	___	___	_____	_____	_____	_____
"	___	___	_____	_____	_____	_____
"	___	___	_____	_____	_____	_____
"	___	___	_____	_____	_____	_____

CHILD'S GRANDPARENTS AND FAMILY:

On paternal (father's) side:	Height	Overweight	Medical conditions
Grandfather	_____	_____	_____
Grandmother	_____	_____	_____
Aunt or Uncle	_____	_____	_____
Aunt or Uncle	_____	_____	_____
Aunt or Uncle	_____	_____	_____

On maternal (mother's) side:	Height	Overweight	Medical conditions
Grandfather	_____	_____	_____
Grandmother	_____	_____	_____
Aunt or Uncle	_____	_____	_____
Aunt or Uncle	_____	_____	_____
Aunt or Uncle	_____	_____	_____

In the family, is there anyone who has or who has had:

Diabetes Mellitus	Yes _____	No _____
Goiter or Thyroid problems	Yes _____	No _____
Need to take cortisol	Yes _____	No _____
Early menopause (before age 40)	Yes _____	No _____
Early puberty	Yes _____	No _____
Later puberty	Yes _____	No _____
Delayed growth	Yes _____	No _____
Unusually tall or short stature	Yes _____	No _____

If you have specific concerns or questions you would like answered, please note them here:_____
_____

_____

BRING COMPLETED FORM WITH YOU FOR YOUR ENDOCRINE APPOINTMENT WITH:

UP Health System Marquette Specialty clinic
580 W. College Ave.
Marquette, MI 49855
Phone: (906) 225-7394
Fax: (906) 225-4830

If you have any questions or concerns regarding your child's appointment please call or email Terri Kaski LPN at 906-225-7394 or email terri.kaski@mghs.org