**Stephen L. Aronoff, M.D., F.A.C.E.**
Diplomate of the American Board of Internal Medicine and the Subspecialty Board of Endocrinology and Metabolism
2400 Lakeside Blvd., Suite 130, Richardson, TX 75082
Phone: 214-774-4475 Fax: 214-432-5392

# PEDIATRIC PATIENT HEALTH HISTORY

***Please fill in the blank lines or mark with a check where appropriate:***

## I. Contact Information

***Name of Patient:***_____ Boy ☐ Girl ☐
Nickname:_____ Date of Birth: _____ Age:_____ School grade level:_____
Street Address:_____Apt.#_____
City:_____State:_____ZIPCODE: _____
Home Phone:_____

Name of Parent(s) or Legal Guardian(s): _____
Street Address:_____Apt.#_____
City:_____State:_____ ZIPCODE:_____
Home Phone:_____Work Phone:_____Cell Phone:_____

Does child live with parent(s)/legal guardian(s)? Yes☐ No☐
If no, please provide name(s) of such person(s):_____
Relationship to patient:_____ Home Phone:_____
Work Phone:_____Cell Phone:_____

Other Emergency contact person:_____Relationship:_____
Address:_____
City:_____State:_____ZIPCODE:_____
Phone#:_____ Alternate Phone#:_____

Pharmacy name & address:_____Phone#:_____

## II. PATIENT'S REASON FOR OFFICE VISIT:_____
_____
_____

## III. General Information:

1. Is your child involved in any special activities? (sports, school clubs, youth groups, toddler/preschool programs, etc.) No____ Yes ____ If yes, please describe briefly: _____
_____
_____

2. Is your child involved in regular physical activity? No☐ Yes☐
If yes, what type? _____How often?_____

**[III. General Information -- continued from page 1]**

3. Please indicate (check) your child's type of diet:

☐ Balanced (all nutrition groups) ☐ Diabetic ☐ Vegetarian
☐ Gluten Free ☐ Low Fat ☐ Lactose Intolerant ☐ Vegan
☐ Other: Please explain_____

4. Does your child have any body piercings: Yes☐ No☐ AND/OR tattoos: Yes☐ No☐

5. Does your child:

Smoke: Yes ☐ No☐ Not sure☐
Drink Alcohol: Yes☐ No ☐ Not sure☐

## IV. Medications

**Has your child had a recent influenza vaccination?** Yes: ☐ Date:_____ No ☐

**Has your child had all recommended vaccinations for his/her age?** No ☐ Not sure ☐
Yes ☐ Date of last immunization: _____

**Does child take medications?** Yes ☐ No ☐ Vitamins or supplements? Yes ☐ No ☐

**Please list any known drug allergies or other negative reactions to medications:** None ☐
_____
_____

***Please list all diabetes medications separately on Pages 7 and 8, in section III "for a child with diabetes."***

***Below, please list all other medications including inhalers, vitamins and supplements.***

| Medication Name | Dose (mg, ml, sprays, etc.) | Frequency (per day, per week, etc.) | Age Started (or give date) |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |
| 6. | | | |

**V. BIRTH HISTORY**: (if child is adopted, please provide as much information as is known)

1. Child is adopted Yes ☐ No ☐

2. Mother's age at child's conception:_____years

3. Was conception natural or assisted?_____

4. Were there complications during pregnancy? Yes ☐ No ☐ If yes, please explain: _____
_____
_____

5. Did mother take medication during pregnancy? Yes ☐ No ☐ If yes, please explain: _____
_____
_____

5. Did mother smoke during pregnancy? Yes ☐ No ☐

6. Was pregnancy full term? Yes ☐ No ☐ If no, indicate number of months or weeks:_____

7. Conditions of child's delivery:
   "Normal"/vaginal: Yes ☐ No ☐ C-section: Yes ☐ No ☐
   Forceps: Yes ☐ No ☐ Vacuum: Yes ☐ No ☐
   Cord around baby's neck: Yes ☐ No ☐ Multiple births (twins, etc.) Yes ☐ No ☐

8. Child's birth information: Weight: ____lbs/ ____oz. Length: _____Inches
   Apgar Scores (if known): _____

**VI. Developmental History:**

Please indicate age of child at the time of the following milestones:

| | |
|---|---|
| First began crawling: | _____months |
| First step: | _____months |
| First word: | _____months |
| First tooth: | _____months |
| First tooth lost: | _____years |
| Start of pubertal changes: | _____years |
| Girl's first menstrual period: | _____years |

**VII. FAMILY HEALTH --** If patient is adopted, or family history is unknown, check here: ___

***Please provide the following information:***

Mother's date of birth:_____Height:_____Weight:_____Age at puberty:_____
Father's date of birth: _____Height:_____Weight:_____Age at puberty:_____

**Is child here to be evaluated for delayed growth (being a "late bloomer") ?** Yes ___ No ___ If yes, please tell us if any other member of the patient's immediate family (siblings, parents, grandparents) was also late in developing in the teenage years and, if so, which family member(s):_____
_____

***Family Health History:***

| Please check all that apply | Father | Mother | Grandfather | | Grandmother | | Aunt | | Uncle | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | Paternal | Maternal | Paternal | Maternal | Paternal | Maternal | Paternal | Maternal |
| **Diabetes** | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| **Heart Disease** | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| **High Blood Pressure** | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| **Osteoporosis** | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| **Thyroid Problems** | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| **Kidney Problems** | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| **Cancer**<br>**Type of Cancer:** | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

***Sibling information--***

***Please check whether sibling is a brother or sister and fill in the information for each:***

| Brother | Sister | Date of Birth | Age at Puberty | History of Serious Illness |
|---|---|---|---|---|
| ☐ | ☐ | | | |
| ☐ | ☐ | | | |
| ☐ | ☐ | | | |
| ☐ | ☐ | | | |
| ☐ | ☐ | | | |

**VIII. CHILD'S HEALTH REVIEW:**

***Please list any major surgeries and child's age at the time:*** ***[if none, check here ☐]***

1. _____Age:_____
2. _____Age:_____
3. _____Age:_____
4. _____Age:_____

***Please list any major illnesses:*** ***[if none, check here ☐]***

1. _____Age at diagnosis:_____
2. _____Age at diagnosis:_____
3. _____Age at diagnosis:_____
4. _____Age at diagnosis:_____

***OVERALL HEALTH REVIEW -- Please check all conditions that apply to the patient:***

GENERAL

- Fever ___
- Chills ___
- Unusual Fatigue ___
- Weakness ___
- Nervousness ___
- Fainting ___
- Anemia ___
- Pain ___
- Sleep Problems ___
- Food Allergies ___
- Rapid Weight Changes ___
- Unusual Sweating ___
- Emotional or Psychological Issues ___
- Seizures or Convulsions ___

EARS/NOSE/THROAT/RESPIRATORY

- Hearing impairment ___
- Hearing aid use ___
- Ringing in ears ___
- Neck pain ___
- Difficulty swallowing ___
- Hoarseness/Cough ___
- Sinus Infections ___
- Nosebleeds ___
- Asthma ___
- Allergies ___

URINARY TRACT

- Infection ___
- Pain when Voiding ___
- Frequent Urination ___
- Blood in Urine ___
- Kidney Stones ___

EYES

- Vision changes ___
- Vision loss ___
- Pain when Looking at light ___
- Unexplained Eye pain ___
- Cataracts ___
- Eye injuries ___

HEAD

- Dizziness ___
- Headaches ___
- History of Head Injury ___
- Stroke ___

SKIN

- Rashes ___
- Itching ___
- Hives ___
- Easy Bruising ___
- Changes in Hair ___

## ***ENDOCRINE and METABOLIC SYSTEMS REVIEW***

**I. General review -- Please check all conditions that apply to the patient:**

For Boys and Girls:

- Rapid weight change ___
- Heat intolerance ___
- Cold intolerance ___

For Girls Only:

- Irregular menstrual periods ___
- Excessive facial or body hair ___

**II. <u>Regarding patients with thyroid problems</u> -- please mark with a check if child has the following:**

| | | |
|---|---|---|
| Enlarged thyroid | Yes___ | No___ |
| Thyroid nodule(s) | Yes___ | No___ |
| Underactive thyroid | Yes___ | No___ |
| Overactive thyroid | Yes___ | No___ |
| Thyroid cancer | Yes___ | No___ |

**III. <u>Regarding children with diabetes</u> -- please complete the following section:**

**1. General information:**

Age of Diagnosis _____ Date of last eye exam:_____
Date of last microalbumin_____ Results (check one): Normal____Abnormal____
Date of last Hgb A1C _____ Value:_____%
Do child use a glucose meter? (check one) Yes____ Brand name:_____ No____
Frequency of blood sugar testing_____times per day.
Blood sugar range_____
Does patient use a CONTINUOUS GLUCOSE MONITOR (CGM)? Yes____ No____

**2. Regarding patients using oral medication only OR using oral medication plus insulin:**

List oral medications: 1._____Dose_____
2._____Dose_____
3._____Dose_____
4._____Dose_____

Does child use oral medication plus insulin? Yes____ No____
If yes, please provide the following information:
Long acting insulin -- Brand:_____
Time of day and amount for each:_____
Short acting Insulin -- Brand:_____
Time of day and amount for each:_____
Pre-mixed Insulin -- Brand:_____
Time of day and amount for each:_____

For patients using oral medication plus insulin:
Is the insulin dose adjusted?_____If so, by what method? _____
_____

**3. Regarding patients injecting insulin only -- please provide the following information:**

Long acting insulin -- Brand:_____
Time of day and amount for each:_____
Short acting Insulin -- Brand:_____
Time of day and amount for each:_____
Pre-mixed Insulin -- Brand:_____
Time of day and amount for each: _____

Is the insulin adjusted?_____ If so, by what method?_____
_____

**4. Regarding patients using an insulin pump -- please provide the following information:**

Brand of pump: _____Date started:_____
Basal Insulin Rates: _____
Insulin/Carb Ratio: _____
Insulin Correction Factor:_____

* * * * *

***I AFFIRM THAT THE INFORMATION PROVIDED ON THIS FORM IS CORRECT TO THE BEST OF MY KNOWLEDGE.***

Signature of Parent or Guardian:_____ Date: _____
***OR:***
Signature of Authorized Representative_____Date: _____
Please print representative's name:_____
Relationship to patient:_____

***Thank you for completing this health history form. The information is important and will help us to better serve your health care needs. If you have questions, please be sure to discuss them with us during your office visit.***