**Patient Intake Form**

**Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

First Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** MI**: \_\_\_\_\_** Last Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

DOB: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Sex: **□**Male  **□**Female

Address: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** City**:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code**: \_\_\_\_\_\_\_\_\_\_**

Mother’s Name (or Legal Guardian): **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Father’s Name (or Legal Guardian): **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Phone Number: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Parent’s Email**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Pharmacy Name/ Location: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Primary Doctor/ Location**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Preferred Lab**: □** LabCorp **□**Quest  **□**Other: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Ethnicity: □Hispanic or Latino □Non-Hispanic or Non- Latino

Race: □White □Black/African American □Asian □American Indian or Alaska Native

 □Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**REASON FOR YOUR VISIT TODAY:**

**□**Type 1 Diabetes **□**Diabetes Evaluation **□**Excessive Hair

**□**Type 2 Diabetes **□**Elevated Insulin **□**Worsening Acne

**□**Excessive Weight Loss **□**Obesity/ Rapid Weight Gain

**□**Elevated Sugars **□**Irregular Periods

**□**Hypothyroid (low) **□**Short Stature/Poor Growth **□**Tall/ Rapid Growth

**□**Hyperthyroid (high) **□**Delayed Puberty **□**Early Puberty

**□**Adrenal Problems **□**Excessive Urination **□**Calcium Imbalance

**□**Pituitary Problems **□**High Blood Pressure **□**Electrolyte Imbalance

**□**Rickets/ Weak Bones **□**Low Blood Sugars

**□**Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SIGNS AND SYMPTOMS (PLEASE CHECK ALL THAT APPLY)**

**□**Fainting Spells **□**Fractures **□**Constipation

**□**Fatigue **□**Dry Skin **□**Poor Appetite

**□**Recent Weight Loss **□**Heavier Periods **□**Trouble Sleeping

**□**Headaches **□**Seizures **□**Feeling Hot all the Time

**□**Feeling Cold all the Time **□**Salt Craving **□**Diarrhea

**□**Darkened Skin on Neck **□**Swelling in Neck **□**Easy Bruising /Stretch Marks

**□**Blurred Vision **□**Weakness **□**Exercise Intolerance

**□**Abdominal Pain/Nausea **□**Racing Heart Rate **□**Tremors

**□**Increased Pigmentation **□**Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient’s Birth History**

**Pregnancy:** □ Full Term: \_\_\_\_Weeks **□**Uncomplicated

 **□**Preterm: \_\_\_\_ Weeks **□**Complicated by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**After Delivery**: **□**went home with parent(s) **□**Low blood sugars as Newborn

 **□**Jaundice **□**Hospital stay due to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­

Birth Weight: \_\_\_\_lbs.\_\_\_\_\_oz.

**Allergic to any Medications?**  □No □Yes (If yes, please list)

1. Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reaction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reaction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Medications:**

|  |  |  |
| --- | --- | --- |
| **Medication Name** | **Dose (mg, units, 2 puffs, etc.)**  | **Frequency (once a day, at bedtime, as needed, etc.)**  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Other History of Patient**

Health Problems: **□**ADHD **□**Asthma **□**Allergies: **□**Environmental or **□** Food

**□**Thyroid Disease: **□**Hypothyroid **□**Hyperthyroid Date Diagnosed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**□**Celiac Disease: Date Diagnosed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**□**Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**For Patients with Diabetes**

**□**Type 1 **□**Type 2 **□**Type Unknown Date Diagnosed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Treated with (check all that apply):  **□** Insulin shots **□**Diabetes Pills **□**Diet

Last Hemoglobin A1C: \_\_\_\_\_\_\_% Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

Hospitalized for Diabetes in the last 12 months: **□** Yes **□**No Date(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social and Family History**

Patient lives with?

**□**Mom **□**Dad **□**Brother **□**Sister **□**Stepmother **□**Stepfather **□** other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Grade Level of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Attends Daycare?  **□**yes **□**no

School/ Daycare Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_District: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Biological Parents of Patient

Mother: Height-\_\_\_\_\_\_\_Ft.\_\_\_\_\_\_Inches Age of First Period: \_\_\_\_\_\_\_\_\_Years Old

Family members on mother’s side are: **□**Short **□**Average **□**Tall

Father: Height- \_\_\_\_\_\_\_Ft. \_\_\_\_\_ Inches Age of Puberty: \_\_\_\_\_\_\_\_\_\_\_ Years Old

Family members on father’s side are: **□**Short **□**Average **□**Tall

**Are There Family Members with the Following Conditions? (Check all that Apply)**

 Paternal= Father’s Side Maternal = Mother’s Side

Type 1 Diabetes (Juvenile): **□**Dad **□**Mom **□** Brother **□**Sister **□**Paternal grandfather **□**Paternal grandmother **□**Maternal grandfather **□**Maternal grandmother □ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type 2 Diabetes (Adult Onset): **□**Dad **□**Mom **□** Brother **□**Sister **□**Paternal grandfather **□**Paternal grandmother **□**Maternal grandfather **□**Maternal grandmother □ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Thyroid Disease: **□**Dad **□**Mom **□** Brother **□**Sister **□**Paternal grandfather

 **□**Paternal grandmother **□**Maternal grandfather **□**Maternal grandmother □Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Autoimmune Disease: **□**Dad **□**Mom **□** Brother **□**Sister **□**Paternal grandfather **□**Paternal grandmother **□**Maternal grandfather **□**Maternal grandmother □ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Celiac (Gluten Allergy): **□**Dad **□**Mom **□** Brother **□**Sister **□**Paternal grandfather **□**Paternal grandmother **□**Maternal grandfather **□**Maternal grandmother □ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**For Patients being seen for Short Stature/ Early or Late Puberty**

Very Short Stature (MEN <5’4’’, WOMEN<4’11’’): **□**Dad’s Side **□**Mom’s Side

Early Start of Puberty (GIRLS, <7 YRS, BOYS, <9 YRS): **□**Dad’s Side **□**Mom’s Side

Late Start of Puberty (GIRLS >12 YRS, BOYS > 13YRS): **□**Dad’s Side **□**Mom’s Side

**For Patients being seen for Diabetes/ Rapid Weight Gain**

High Blood Pressure: **□**Dad **□**Mom **□** Brother **□**Sister **□**Paternal grandfather **□**Paternal grandmother **□**Maternal grandfather **□**Maternal grandmother □ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_

High Cholesterol: **□**Dad **□**Mom **□** Brother **□**Sister **□**Paternal grandfather **□**Paternal grandmother **□**Maternal grandfather **□**Maternal grandmother □ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family members with Heart Attack before Age 55: **□**Dad’s Side **□**Mom’s Side

**Past Surgeries or Hospitalizations**

**□**Ear Tubes Date: \_\_\_\_\_\_\_\_\_\_\_\_ **□**Broken a Bone(s): Describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**□**Tonsillectomy Date: \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**□**Adenoidectomy Date: \_\_\_\_\_\_\_\_\_\_\_\_

**□**Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**□**Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_