Huntington Health Physicians

Cedric Ng, MD
Pediatric Endocrinology Questionnaire

In order to help us provide you with better medical care, please complete the following questionnaire to the best of you knowledge. If you have diabetes, please also complete the diabetes questionnaire.

Today's Date: _____ Name: _____

Briefly describe the reason for your visit: _____

Past Medical History Please check if you have had any of the following:

☐ Asthma	☐ Depression	☐ Heart disease	☐ Kidney stones	☐ Poor circulation
☐ Arthritis	☐ Diabetes	☐ Hepatitis	☐ Liver disease	☐ Thyroid disease
☐ Blood clots	☐ Epilepsy	☐ High blood pressure	☐ Migraine	☐ Ulcer
☐ Cancer Type: _____	☐ Genetic Syndromes Type: _____	☐ High cholesterol	☐ Osteoporosis	
		☐ Kidney disease	☐ Pneumonia	
☐ Celiac disease	☐ Gallstones			

Please list any other medical conditions not noted above and approximate dates:

_____ Dates:_____
_____ Dates:_____
_____ Dates:_____

Please list all surgeries, hospitalizations, serious accidents and approximate date:

_____ Dates:_____
_____ Dates:_____
_____ Dates:_____

Please list any allergies to medications and describe the type of reaction:

_____
_____

Medications please list your current medications:

Medication	Dose	How often?	Medication	Dose	How often?

Habits

Exercise type/duration:_____How often per week_____Smoking: ◯ Yes ◯ No

Symptoms please check if you are having any of the following symptoms:

General	**Eyes**	**Heart**	**Neuro**
☐ fever	☐ eye pain	☐ heart rate slow/fast	☐ headache
☐ chills	☐ red eyes	☐ chest pain	☐ confusion
☐ feeling tired	☐ recent change in vision	☐ irregular heart rate	☐ numbness/tingling
☐ weight gain ___lbs	☐ double vision	☐ leg swelling	☐ dizziness
☐ weight loss ___lbs	☐ dry eyes		☐ fainting
☐ trouble sleeping		**Lungs**	☐ limb weakness
☐ anxiety	**Neck / Throat**	☐ shortness of breath	☐ difficulty walking
☐ depression	☐ sore throat	☐ wheezing	
☐ Increased thirst	☐ hoarseness	☐ cough	**Heme / Lymph**
	☐ difficulty swallowing		☐ swollen glands
Stomach / Intestines			☐ easy bleeding / bruising
☐ abdominal pain	**Urinary**	**Musculoskeletal**	
☐ nausea	☐ frequent urination	☐ joint pain	**Skin**
☐ vomiting	☐ getting up at night to urinate	☐ joint swelling	☐ rash
☐ constipation	☐ pain or burning on urination	☐ muscle pain	☐ itching
☐ diarrhea			☐ wound

Birth History:

Gestational age:_____ Birth length:_____ Birth weight_____ Length of NICU stay, if any:_____

Social History:

Mother's Occupation:_____ Father's Occupation: _____

Who do you live with?_____ School:_____ Grade:_____

Doing well in school?_____

Developmental History How old were you when**:**

1st tooth formed: _____1st tooth lost: _____ 1st words: _____

Sat without help: _____ Walked: _____ Potty trained: _____

Family History:

Mother: Mother's height: _____Mother's first menstrual period (age): _____

Father: Father's height: _____ Timing of Puberty: ◯Normal ◯Abnormal Still grew after high school: ◯Yes ◯No

	Age	**Any major illness:**	**If deceased, cause?**
Mother			
Father			
◯sister ◯brother ◯child			
◯sister ◯brother ◯child			
◯sister ◯brother ◯child			
◯sister ◯brother ◯child			

Females (menstrual history):

Age of onset___Cycle every___days ◯Regular ◯Irregular Last menstrual period date: _____

Number of pregnancies:_____ miscarriages:_____abortions:_____ Live births:_____

I certify that the foregoing statements are true to the best of my knowledge.

_____

Patient Signature