Pediatric Endocrinology
Boston Children's Health Physicians

Diabetes and Endocrine Center for Children and Young Adults
(Phone) 914-366-3400 Option#1 for appointments Option #2 for diabetes related questions (Fax) 914-366-3407
https://bchp.childrenshospital.org/practices/endocrinology

Your child, _____ has a Pediatric Endocrine/Diabetes

appointment at the following location, on_____

*Double check your visit location, especially if you rescheduled your visit. Rescheduled location might be different from the initial visit location

Office Locations:	**Address:**
Hawthorne Main office	19 Bradhurst Ave, Suite# 2900S, Hawthorne, NY 10532
Chappaqua	1 South Greeley Ave Suite 303, Chappaqua, Ny 10514
Middletown	212 Crystal Run Road Middletown, NY 10941
Poughkeepsie	1 Webster Ave suite 300, Poughkeepsie, NY 12601
Suffern	257 Lafayette Ave Ste 370, Suffern, NY 10901
Washingtonville	10 Weathervane Drive Washingtonville, NY 10992

You must bring the following information to the first appointment, or you may be asked to reschedule your child's appointment. **Please bring the following items 1 through 5 with you.**

☐1. **Insurance Card/Information**
☐2. **Referral from your referring provider or insurance*** (if mandated by your insurance)
☐3. ***Completed* initial visit forms**
☐4. Your **child's growth chart** (obtain from your physician's office and bring with you)
☐5. **Results of any blood tests/ imaging your child has had in the past year.** If your child had an X-ray prior to the visit, please bring in the **Bone age X-ray CD.**

Please arrive at the check-in desk 20 minutes before your scheduled appointment time.
The pre-appointment time is necessary to check the child's height, weight, and blood pressure, so that the provider can see you without any delays.

If you arrive 15 minutes or more after your scheduled appointment time, you may be asked to reschedule the visit.

***All* cancellations should be made more than 24 hours prior to your appointment.**

To ensure timely service, please complete the following forms and bring to the appointment or complete the forms prior to your appointment via link sent by text/email.
All forms must be completed prior to your scheduled appointment.

Sincerely,
The Division of Pediatric Endocrinology

Boston Children Health Physicians
Pediatric Endocrinology/Diabetes

Initial Consult

Patient Name: _____ DOB: _____

Parent/Patient: Please complete all pages (please print clearly)

What is the Endocrinology referral for/Why are you bringing your child? (Choose all that apply)

☐ Diabetes ☐ Thyroid Problem ☐ High Cholesterol ☐ Poor Growth ☐ Excessive Growth	☐ Thyroid Nodule ☐ High Insulin level/HbA1C ☐ Early Development ☐ Late Development ☐ Abnormal Blood Tests	☐ Calcium Problems/ Bone/ Fractures ☐ Abnormal Xray/ultrasound/MRI ☐ Adrenal Problem ☐ Other: _____ _____

- What other health concerns would you like to discuss today:
  _____
  _____
- Do you see any other specialists? _____
- Other Diagnoses: _____
- Past Hospitalizations: _____
- Past Surgeries: _____
- Food Allergies: _____
- Medication Allergies: _____
- Current Medications: _____
  _____
- Supplements/Vitamins: _____
- Immunizations: _____
- Snoring/ sleep apnea symptoms? _____

FAMILY HISTORY *Important to fill in ***both*** parents' information*

Relative	**Age**	**Height**	**Weight**	**Puberty (early, late, average)**	**Health & Comments**
Father					
Mother					
Mother's mother					
Mother's father					
Father's mother					
Father's father					
Sibling					
Sibling					
Sibling					

Information of medical conditions in other family members (including aunts, uncles, cousins& blood relatives):

Illness	**Relative(s) & Details**
Diabetes	
Thyroid Disease	
Early Puberty/ Late Puberty	
Short Stature	
Other hormonal diseases, (PCOS)	
High blood pressure	
Bone disease/ Osteoporosis/ fracture	
Liver/ Kidney / Lung Disease	
Any Cancer diagnosis	
Heart Disease (<55 yrs)/ Cholesterol	
Any other diseases happen in multiple family members?	

REVIEW OF SYSTEMS:

Please check yes or no for the following symptoms your child may be experiencing Y=Yes / N=No

		Y	N		Y	N		Y	N
Constitutional	Weight loss/gain			Fever			Fatigue		
Eyes	Double vision			Eye swelling			Redness/pain		
ENT	Throat pain			Ear infection			Nosebleeds		
Cardiovascular	Chest pain			Palpitations			Murmur		
Respiratory	Shortness of breath			Cough			Wheezing		
Gastrointestinal	Nausea/vomiting			Diarrhea			Abdominal pain		
Genitourinary	Urinating frequently			Allergy to meds			Urinary infection		
Endocrine	Excessive thirst			Excessive Urination			Weight loss/gain		
Skin	Rash			Lesions			Birthmarks		
Musculoskeletal	Joint swelling			Joint pain			Scoliosis		
Neuro	Headache			Fainting			Dizziness		
Psych/Behavioral	Difficulty sleeping			Depression			Anxiety		
Hematology/Lymph	Bruising/bleeding			Anemia			Swollen glands		
OTHER									

Have menstrual periods begun: ☐ No ☐ Yes ☐ N/A Age of onset of Menses: _____

Cycles regular (every month-30-35-day cycle): ☐ No ☐ Yes. If not, explain_____

Date of last menstrual period_____ Menstruation concerns: _____

Developmental/Social History

Medications taken by mother during pregnancy: _____

If pregnancy complicated, please explain: _____

Full Term (>38 weeks) ☐ Yes ☐ No **Premature:** _____ weeks

Delivery: ☐ Vaginal ☐ Cesarean Reason for C-section: _____

Birth weight_____**Length at birth:** _____

Any problems in nursery (jaundice, cyanosis, NICU stay, hypoglycemia)? ☐ Yes ☐ No

If yes, please explain: _____

Please answer when your child met developmental milestones and describe any issues.

Milestone	Ontime	Late	Milestone	Ontime	late
Roll Over	☐	☐	Speech	☐	☐
Walking	☐	☐	Toilet Train	☐	☐

Occupational / Physical / Speech therapy: _____ Ongoing: ☐Yes /☐ No

Grade in school: _____

School performance: ☐ Below Grade Level ☐ Grade Level ☐ Above Grade Level ☐ IEP: Yes /No ☐ 504 plan

Diet problems: _____

Sleep problems: _____

Your child's sleep/bedtime_____

How many hours of sleep per night? _____

Screen time limit ☐ Yes ☐ No

Child lives with both parents/ separate households_____

If separate households, preferred contact phone number: _____

Parent/Patient Signature: _____**Date completed:** _____

Patient Name: _____ **DOB:** _____

We would like to know about your child's lifestyle habits: Please answer the following questions as best you can, **either select a choice, or write in your answer:**

1. Does your child exclude any major food groups? Gluten / Fish / Meat / Eggs / Milk/ Vegetables/ others

2. Does your child eat breakfast everyday? Yes/ No.

3. **Does your child eat breakfast at home?**
   ☐ Never ☐ Only on weekends ☐ Everyday ☐ 1x/week ☐ 2–3x/week ☐ 3–4x/week ☐ Other: _____

4. What is the usual breakfast?_____

5. Preferred daily beverage:_____

6. **How much milk does your child drink each day?**
   ☐ None ☐ <1 cup ☐ 1–2 cups ☐ 3–4 cups ☐ >4 cups ☐ Other: _____

7. **What kind of milk do you keep in the home?**
   ☐ None ☐ Chocolate ☐ Whole ☐ 2% ☐ 1% ☐ Skim ☐ Skim Plus ☐ Other: _____

8. **Does your child eat any other calcium-containing foods like yogurt, ice cream, cheese, or calcium-fortified orange juice each day?**
   ☐ 1x/day ☐ 2x/day ☐ 3x/day ☐ Every other day ☐ Other: _____

9. **How often does your child have fast food (McDonald's, Wendy's, etc.) or eat out?**
   ☐ >2x/week ☐ 1x/week ☐ 1x/month ☐ Never ☐ Other: _____

10. **How much regular soda (Coke, Ginger Ale, etc.) does your child drink?**
    ☐ None ☐ 1 can/day ☐ More than 1 can/day ☐ Other: _____

11. **How much juice (Capri Sun, Orange, Apple, Sunny Delight, etc.) does your child drink?**
    ☐ None ☐ 1 glass/day ☐ 2–3 glasses/day ☐ More than 3 glasses/day ☐ Other: _____

12. **Does your child eat fruit?**
    ☐ Never ☐ Rarely ☐ 1x/day ☐ 2x/day ☐ 3–4x/day ☐ >4x/day ☐ Other: _____
13. **What fruit does your child eat?**
    ☐ Bananas ☐ Apples ☐ Oranges ☐ Strawberries ☐ Melon ☐ Grapes☐ Pineapple ☐ Mango ☐ Kiwi ☐ Other: _____

14. **How often does your child eat green vegetables (broccoli, celery, cucumbers, spinach, green beans, salad)?**
    ☐ Never ☐ 1x/day ☐ >2x/day ☐ 1x/week ☐ 2–3x/week ☐ 3–4x/week ☐ Other: _____

15. **How many days each week does your child buy school lunch?**
    ☐ None ☐ 1x/week ☐ 2–3x/week ☐ 3–4x/week ☐ 5x/week ☐ Other: _____