University of Illinois Medical Center | CHILDREN'S HOSPITAL UNIVERSITY OF ILLINOIS

To the Parent/Guardian of:

Welcome to the Diabetes Clinic!

Your child has been scheduled for an appointment in Diabetes Clinic of the Children's Hospital University of Illinois

on: at: with:

We have enclosed a medical history form along with information about the Diabetes Clinic. Please fill out the medical history form ahead of time and bring to the clinic appointment and review the enclosed information. If this information applies to you, we ask that you bring your child's blood sugar records and insulin doses for the last 14 days with weekly meal time and bedtime blood sugar averages. If your child uses an insulin pump, please bring the total daily insulin and total daily bolus and basal insulin doses for the last 7 days as recorded in the pump. You will be asked to fill out a 24 hour food history when you arrive.

Please arrive 15 minutes before the scheduled appointment time to allow for parking and registration. The Diabetes clinic is inside the Children and Adolescent Center in 2E of the outpatient care center.
If you have any questions please call the Diabetes Clinic at (312) 996-1795 or fax (312) 996-8218.

We look forward to meeting with you.

The Diabetes Team

Bienvenidos a la clínica de Diabetes

Su hijo/hija tiene una cita en la clínica de diabetes del Hospital de niños de la Universidad de Illinois:
Fecha: Hora: Con:

Por favor complete el cuestionario adjunto y lo tráigalo el día de su cita. Traiga también un diario con las mediciones de azúcar de su hijo/a y dosis de insulina de por lo menos las últimas 2 semanas. Incluya el promedio del azúcar en sangre a la horas de los alimentos y al acostarse. Si utiliza una bomba de insulina traiga las doses de insulina basales, insulina total por día y total de bolos de insulina por día de los últimos 7 días.

Favor de llegar a la clínica 15 minutos antes de su cita. Se puede estacionar en el estacionamiento adjunto al centro de pacientes externos. La clínica de Diabetes se encuentra dentro del Centro para Niños y Adolescentes en el segundo piso sección 2E.
Para cualquier duda por favor comuníquese a la división de Endocrinología y Diabetes al Teléfono: 312-996-1795 o al Fax: 312-996-8218.

Atentamente,
El equipo de diabetes

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Endocrine and Diabetes Clinic

Patient History

Dear Parent,

Your child has an appointment in the Endocrine and Diabetes Clinic. We can serve you better if we have his or her full medical history. **Please answer these questions before your appointment if possible, and bring the form with you**. Use extra paper or write on the back page of the form if needed.

Thank you

Child's full name: _____ Birthdate: ___/____/____

Father's full name: _____ Birthdate:____/____/____

Mother's full name: _____ Birthdate: ___/____/____

Parent's marital status: ⎕married ⎕single ⎕divorced ⎕widowed

Who has legal custody of this child? ⎕Shared ⎕mother ⎕father ⎕guardian

Home address _____

City _____ State _____ Zip Code _____

Preferred contact telephone number (_____) _____

Your child's primary doctor _____ Phone (_____)_____

Please describe the reason your child was referred to our clinic.

_____

_____

_____

MEDICAL HISTORY

Pregnancy and birth history. Please respond about the pregnancy with this child.

Pregnancy lasted _____ ⎕weeks ⎕months

Did mother smoke during pregnancy? ⎕No ⎕Yes . Drink alcoholic beverages during pregnancy? ⎕No ⎕Yes

use recreational drugs during pregnancy? ⎕No ⎕Yes

Were there any problems during pregnancy or with delivery? ⍐No ⍐Yes Please describe:_____

_____

Baby's birth weight _____ length_____ Brought baby home after _____ days

Breast milk ⍐yes ⍐no how long? _____ Formula ⍐yes ⍐no how long?_____

Please describe any problems during the first 2 months of life: _____

_____

DEVELOPMENT

How old was your child when he/she could: Sit without help _____ Walk_____ Run_____

Hop _____ Ride tricycle _____ Toilet trained _____Said first word _____

First 2-3 word sentence _____ First tooth _____ All 20 baby teeth _____

Overall, did this child develop slower, faster, or about the same as other children? _____

School grade: _____ How is your child doing in school?⍐Above average ⍐Average ⍐Below average

Does your child require special education? _____Last report card grades _____

PUBERTY

Has your child started to show pubertal development? ⍐Unsure ⍐No ⍐Yes If yes, how old was your child when you first noticed: growth spurt _____ penis growth _____

Breast growth _____ body odor_____ testicle growth _____

First period _ _____ underarm hair _____ facial hair _____

Regular periods _____ pubic hair _____ voice change _____

MEDICATIONS (list all medicines, vitamins, and supplements including dose and approximate date started)

See medication list

Medication name/dose/frequency	**Start date**		**Medication name/dose/frequency**	**Start Date**

ALLERGIES (list all allergies and reaction) _____

_____

IMMUNIZATIONS/VACCINES ⍐Up to date⍐Not up to date ⍐We do not vaccinate ⍐Unsure

_____

SURGERIES/OPERATIONS (list any surgeries your child has had)

date	surgery	performed by- if known	where performed

HOSPITALIZATIONS (hospital stays not listed above)

date	reason for hospitalization	name of hospital, city, state

MEDICAL PROBLEMS (list problems with any of the following including details)

Skin problems, spots, or birthmarks _____

Brain, nerves, headaches _____

Vision, hearing, taste, or smell _____

Heart or blood pressure _____

Breathing _____

Weight or height _____

Eating (swallowing, appetite) _____

Stomach or bowels (constipation, diarrhea) _____

Kidneys, bladder, or urination _____

Frequent infections _____

Muscles or bones _____

Weakness or coordination _____

Blood _____

Psychiatric or behavior_____

Sleep (restless, snoring, sleepwalking)_____

Activity/energy _____

FAMILY HISTORY Please answer these questions about blood relatives (use back page of form if needed). Please indicate if a parent was adopted.

	age	height/weight	age at puberty	health problems
Birth father	_____	_____	first shaved _____	_____
Birth mother_	_____	_____	first period _____	_____
Birth sibling M/F	_____	_____	_____	_____
Birth sibling M/F	_____	_____	__ _____	_____
Birth sibling M/F	_____	_____	_____	_____
Birth sibling M/F	_____	_____	_____	_____

Birth father's family (paternal side):

	age	height/weight	health problems
Father's father	_____	_____	_____
Father's mother	_____	_____	_____
Father's brothers	_____	_____	_____ _____
Father's sisters	_____	_____	_____

Birth mother's family (maternal side):

	age	height/weight	health problems
Mother's father	_____	_____	_____
Mother's mother	_____	_____	_____ _____
Mother's brothers	_____	_____	_____
Mother's sisters	_____	_____	_____ _____

Other biologic family: Does anyone in the family have problems with anything listed below? Please list which side of the family relative to your child (for example, maternal grandmother).

Poor growth _____ ____ Thyroid problems _____

Early or late puberty _____ Adrenal hormone problems _____

Diabetes _____ Kidney problems _____

High cholesterol _____ Heart attack before age 55_____

High blood pressure _____ Stroke before age 55_____

Developmental delays _____ Childhood death _____

Tumors in children _____ Marriage between relatives _____

SOCIAL HISTORY

Who lives with this child? _____

If parents are not together, does he/she spend time with both parents? _____

Are there any pets? _____ Does he/she attend daycare? _____

Is your child involved in activities (music, sports, dance, scouting, church, etc)? _____

_____

Is there anything else you think we should know about your child? _____

_____

Parent's signature _____ Date _____

Staff signature _____ Date/time _____