Pediatric Endocrinology

NewYork-Presbyterian
Phyllis and David Komansky Center for Children's Health
Weill Cornell Medical Center

Weill Cornell Medical Center
New York Presbyterian Hospital
505 E 70th Street 3rd Floor
New York, NY 10021
Phone: 212-746-3462
Fax: 646-962-0265

Maria Vogiatzi, MD
Director, Pediatric Endocrinology

Zoltan Antal, MD
Oksana Lekarev, DO
Marisa Censani, MD

PEDIATRIC ENDOCRINE QUESTIONNAIRE

Please complete this questionnaire. It will be an important part of your child's medical record.

Patient Name: Today's Date:

DOB: Age: MR #:

Name of Person Completing Questionnaire:

Relationship to Patient:

How did you learn about our practice?

What is the reason for the referral to a pediatric endocrinologist?

☐ **Pediatrician**:
Address: Telephone:

☐ **Self-Referral**

☐ **Referring Physician**:
Address: Telephone:

Would you like a report of your visit sent to your Pediatrician and/or Referring Doctor? ☐Y ☐N

PLEASE TELL US ABOUT YOUR CHILD

BIRTH HISTORY:

Was your child born premature? ☐ Y ☐ N
If YES, how many weeks/months:

What was the birth weight?:
What was the birth length?:

Any problems during pregnancy? ☐ Y ☐ N
If YES, please explain:

Any problems after birth? ☐ Y ☐ N
If YES, please explain:

MEDICAL HISTORY:

Does your child have any chronic condition(s)? ☐ Y ☐ N
If YES, please explain:

Does your child take any medication on a regular basis? ☐ Y ☐ N

If YES, please complete:

MEDICATION	DOSAGE	START DATE

Has your child ever been admitted to a hospital? ☐ Y ☐ N

REASON FOR ADMISSION	DATE/AGE	HOSPITAL

Has your child ever had any surgery? ☐ Y ☐ N

TYPE OF SURGERY	DATE/AGE	HOSPITAL/DOCTOR

FAMILY HISTORY:

Mother's Height:
Father's Height:

Does anybody in your family have/had:

			Family Member(s)
Diabetes requiring insulin	☐ Y	☐ N	-
Diabetes treated w/oral medication or diet	☐ Y	☐ N	-
Hypothyroidism	☐ Y	☐ N	-
Other Thyroid problem	☐ Y	☐ N	-
Irregular menses	☐ Y	☐ N	-
Infertility problem	☐ Y	☐ N	-
Sudden death in the family	☐ Y	☐ N	-
Other chronic illnesses	☐ Y	☐ N	-
Short stature or poor growth	☐ Y	☐ N	-

REVIEW OF SYSTEMS:

Does your child have/had:

			Please Explain:
Respiratory or heart problems	☐ Y	☐ N	-
Frequent infections	☐ Y	☐ N	-
Frequent vomiting	☐ Y	☐ N	-
Diarrhea/Constipation	☐ Y	☐ N	-
Recent weight loss	☐ Y	☐ N	-
Recent significant weight gain	☐ Y	☐ N	-
Frequent urination/ urination at night	☐ Y	☐ N	-
Excessive thirst	☐ Y	☐ N	-
Frequent headaches	☐ Y	☐ N	-
Visual problems	☐ Y	☐ N	-

Hearing problems	☐ Y	☐ N	-
Frequent fractures	☐ Y	☐ N	-

Acne/Extra facial or body hair/ hair loss	☐ Y	☐ N	-
Learning difficulties at school	☐ Y	☐ N	-
Emotional/Behavioral problems	☐ Y	☐ N	-

Are you concerned about your child's diet? ☐ Y ☐ N

If YES, please explain:

(Please answer following only if there are concerns regarding diet)

Please describe his/her diet on a typical day: Breakfast:

Lunch:

Dinner:

Snacks: How many/day?

Type of foods:

Drinks:	NO	YES	Ounces per day
Regular soda	☐	☐	
Fruit Juices	☐	☐	
Milk	☐	☐	

Do you have any other concerns about your child? ☐ Y ☐ N

If YES, please explain:

SOCIAL HISTORY

For infants and toddlers: Who is the primary caregiver?

Does the child attend nursery? ☐ Y ☐ N

For school age children: Grade: Special School ☐ Y ☐ N

Specific School Concerns if any:

Tell us who is living in the same household:

Is there any concern about the family that we need to need to know? ☐ Y ☐ N

If YES, please explain:

ALLERGIES

Does your child have any allergies to any medications? ☐ Y ☐ N

If YES, please complete: Name of Medication Symptoms

Does your child have food allergies or allergies to other substances **including latex?** ☐ Y ☐ N

If YES, please complete: Name of food/substance Symptoms

SMOKING (for children older than 13 years)

Does your child smoke, to the best of your knowledge? ☐ Y ☐ N
If YES, please complete: How many cigarettes a day? For how long?

Please tell us the best way to contact you if we need to reach you regarding results.

		Mother	Father	Other
Home Phone:	- -	☐	☐	☐ -
Cell Phone:	- -	☐	☐	☐ -
Work Phone:	- -	☐	☐	☐ -

Can we leave a message regarding results on your answering machine? ☐ Y ☐ N

Name of person completing this questionnaire:
Relationship to patient:

GROWTH IS AN IMPORTANT ASPECT OF *ANY* ENDOCRINE EVALUATION. PLEASE SEND US A COPY OF YOUR CHILD'S GROWTH CHART PRIOR TO YOUR VISIT (even if your child is not coming for an evaluation of growth). (Does not apply to children who are followed by Cornell Faculty Practice)

Race and Ethnicity Information

We want to make sure that all our patients get the best care possible. We would like you to tell us your child's racial and ethnic background as well as your preferred language so that we can review the treatment that all patients receive and make sure that everyone gets the highest quality of care. You may decline to answer if you wish.

The only people who see this information are registration staff, administrators for the practice, your care providers, and the people involved in quality improvement and oversight, and the confidentiality of what you say is protected by law.

Please mark the appropriate response:

Primary Language

☐ Albanian	☐ American Sign Language	☐ Arabic	☐ Armenian
☐ Bengali	☐ Bosnian	☐ Cantonese (Chinese)	
☐ Creole	☐ Croatian	☐ ECH	☐ Danish
☐ English	☐ French	☐ German	☐ Greek
☐ Hebrew	☐ Hindi	☐ Indonesian	☐ Italian
☐ Japanese	☐ Korean	☐ Latin	☐ Malay
☐ Mandarin (Chinese)		☐ Persian	☐ Polish
☐ Portuguese	☐ Romanian	☐ Russia	☐ Serbian
☐ Slovak	☐ Spanish	☐ Swahili	☐ Swedish
☐ Tagalog	☐ Thai	☐ Turkish	☐ Urdu
☐ Vietnamese	☐ Yiddish	☐ Yugoslavian	☐ Other
☐ Declined	☐ Unknown		

Race

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Island
- ☐ White
- ☐ Other Combination Not Described
- ☐ Declined

Ethnicity

- ☐ Hispanic or Latino or Spanish Origin
- ☐ Not Hispanic or Latino or Spanish Origin
- ☐ Declined

Pharmacy Information

So that you and your physician may take advantage of e-prescribing, we need you to provide information on the pharmacy that you choose to use to fill you or your child's prescriptions. Electronic prescription requests are more efficient, accurate and cost effective. Feel free to speak with your physician if you have additional questions.

☐ New

Date:

Patient Name:

NYH #:

PRIMARY

Pharmacy Name:

Address:

Phone Number:

Fax Number:

SECONDARY (if applicable)

Pharmacy Name:

Address:

Phone Number:

Fax Number:
