NorthEast Pediatric Endocrinology
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NEW PATIENT INFORMATION

Date: _____
Name: _____Age:_____DOB:_____
Parent/guardian: _____
Address: _____City:_____State:_____Zip:_____
Home phone: _____Work phone:_____Cell phone: _____
Email:_____

SOCIAL HISTORY

Are parents: _____Married _____Separated _____Divorced _____Never married?
Who lives with patient? _____
Grade Level _____ School performance _____
Mother's occupation _____Father's occupation _____
Smokers in household _____

FAMILY HISTORY

RELATION	AGE	HEIGHT	WEIGHT	MEDICAL CONDITION
Mother				
Mother's Mother				
Mother's Father				
Father				
Father's Mother				
Father's Father				
Sibling (M/F)				
Sibling (M/F)				
Sibling (M/F)				

Pt. Name: _____
Pt. DOB: _____

Are there any family members listed above or not listed above who have any of the following diseases? If yes, please indicate the family member's relation to the patient.

DISEASE	YES	NO	IF YES, WHAT IS RELATION TO PATIENT?
Adrenal Disease			
Asthma/Allergies			
Calcium problems/Osteoporosis			
Cholesterol problems			
Diabetes			
Heart disease/Blood pressure problems			
Kidney disease			
Pituitary disease			
Thyroid disease			
Tumors/Cancer			
Stomach/colon conditions			
Vitiligo			
Other			
Other			

PAST MEDICAL HISTORY/BIRTH HISTORY

Was the patient: ____Full-term ____Pre-term? Method of delivery: ____Vaginal ____C-section
Birth weight: _____ Complications: _____

Please list any major medical conditions the patient has: _____
_____
_____

Please list any hospitalizations or injuries the patient has had: _____
_____
_____

Allergies to medications or other: _____
_____

Please list any current over-the-counter or prescription drugs used by the patient:

DRUG	DOSE (amount/frequency)	HOW LONG USED?