COPEDS

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ENDOCRINOLOGY PATIENT HISTORY

INSTRUCTIONS: Please fill out this questionnaire to the best of your ability. If you are unable to answer a question, please leave the space blank. If you are not sure how to answer a question, the doctor will help you.

MEDICAL HISTORY:

Child's name _____
Birthdate _____ age _____ years _____ months
Your relationship to this child _____

PHYSICIAN'S NOTES:

Physician _____

MATERNAL HISTORY:

Mother's age at time of this pregnancy _____ Total no. of pregnancies _____
Which pregnancy was this _____
Was the baby born early? _____ Late? _____ Near due date? _____
How many pregnancies have been lost _____ Still born _____
Was the pregnancy with this child complicated by: (check all that apply)
☐ High blood pressure, ☐ diabetes, ☐ swelling, ☐ toxemia, ☐ bleeding, ☐ fever,
☐ Infection, ☐ skin rash, ☐ other illness _____
What medications or drugs were used during the pregnancy _____
_____
How many packs of cigarettes were smoked per day _____
How many glasses of beer, wine or other alcoholic beverages were consumed:
Per day _____ Per week _____
How long did the labor last before delivery _____
Was the infant delivered: ☐ head first, ☐ feet first
Were forceps used .....☐ yes ☐ no
Was the delivery by C-section.....☐ yes ☐ no

PERINATAL HISTORY:

Did the baby have trouble breathing right after the birth.....☐ yes ☐ no
Did the baby need oxygen.....,☐ yes ☐ no
During the first few days of life did the baby have: (Check all that apply)
☐ blueness, ☐ jaundice, ☐ low or high blood sugar, ☐ breathing problems,
☐ calcium problems, ☐ infections, ☐ feeding problems, ☐ bladder or kidney problems,
☐ bowel or stool problems, ☐ other _____
What age did the infant go home _____
Birthweight _____ Birth length _____

HAS THE CHILD HAD IN THE PAST OR DOES THE CHILD NOW HAVE PROBLEMS WITH (check all that apply)

☐ vision	☐ thyroid disorder	☐ anemia	☐ swelling
☐ hearing	☐ calcium disorder	☐ bedwetting	☐ seizures or convulsions
☐ speech	☐ allergies	☐ early sexual development	☐ nervousness
☐ feeding	☐ frequent infections	☐ late sexual development	☐ sleeping
☐ vomiting	☐ recurrent ear infections	☐ muscle weakness	☐ learning problems
☐ constipation	☐ frequent headaches	☐ scoliosis	☐ tiredness
☐ diarrhea	☐ pneumonia	☐ joint pain	☐ cancer
☐ frequent abdominal pains	☐ bronchitis	☐ arthritis	☐ slow growth
☐ weight loss	☐ asthma	☐ bone pain or disease	☐ fast growth
☐ obesity	☐ heart murmur	☐ frequent bone fractures	☐ recurrent unexplained fevers
☐ low blood sugar	☐ high blood pressure	☐ skin problems	☐ other _____
☐ high blood sugar	☐ kidney or bladder problems		_____
☐ diabetes			

(OVER)

At what age did the child first:
Sit _____ walk _____ speak words _____ speak sentences _____
What grade is the child in _____
How well is your child doing in school?
☐ excellent, ☐ above average, ☐ average, ☐ below average
Does your child have suspected or diagnosed learning disabilities.....☐ yes ☐ no
What sports, activities or hobbies is he/she involved with _____
_____
GIRLS: Have menstrual periods started.....☐ yes ☐ no
If yes, at what age was first period _____
When was her last period _____
Are they regular.....☐ yes ☐ no
Is she, or has she been on birth control pills.....☐ yes ☐ no
Are the child's immunizations up-to-date.....☐ yes ☐ no
Does the child react to or is he/she allergic to any medications.....☐ yes ☐ no
If yes, which ones _____
Has the child has surgery..... ☐yes ☐ no
If yes, what type and at what age _____
Has the child had any serious accidents.....☐ yes ☐ no
If yes, please explain _____
What medications has the child been on recently: (use margin if needed) _____
_____
_____

FAMILY HISTORY:
Natural father: age _____ height _____ weight _____
Serious illness _____
Natural mother: age _____ height _____ weight _____
Serious illness _____
How many natural brothers does the child have _____ Ages _____
How many natural sisters does the child have _____ Ages _____
How many siblings are "half" brothers _____
How many siblings are "half" sisters _____
How many adopted children are in the family _____
Are any of the other children being treated for any serious or chronic illness.....☐ yes ☐ no
If yes, what are the problems _____
_____
Do any of the child's grandparents, uncles, aunts or cousins have problems with :
(check all that apply)
☐ diabetes, ☐ low blood sugar, ☐ thyroid disorders, ☐ growth problems, ☐ cystic fibrosis,
☐ fertility problems, ☐ cancer, ☐ heart disease, ☐ blood pressure, ☐ liver disease,
☐ kidney disease, ☐ kidney stones, ☐ tuberculosis, ☐ seizures, ☐ mental retardation,
☐ other _____
_____
_____

Please add any additional concerns or information you might think would be important: