PHOENIX CHILDREN'S Medical Group®

Division of Endocrinology and Diabetes

PATIENT QUESTIONNAIRE
NEW PATIENTS

Apply Patient Label

Thanks for coming in.

So we can better care for your child, please answer the following questions before your appointment.

Name of person completing form: _____ **Relationship to patient:** _____

What is the most important concern we can address at your clinic visit? _____

_____

Has your child had any of the following symptoms that interfered with daily activities? Check all that apply:

Constitutional:	☐ weight loss ☐ weight gain ☐ fever ☐ illness ☐ very tired ☐ sleep disturbances
Endocrine:	☐ very thirsty ☐ urinating large amounts ☐ very hungry ☐ very tired ☐ feeling hot ☐ feeling cold ☐ unusual body odor ☐ period before age 9
Dermatological:	☐ rash ☐ loss of hair ☐ change in skin color ☐ stretch marks
Ear/Nose/Throat:	☐ sore throat ☐ nasal discharge ☐ hearing loss
Vision:	☐ eye problems ☐ vision problems
Respiratory:	☐ cough ☐ shortness of breath ☐ snoring
Cardiovascular:	☐ heart flutter ☐ chest pain
Gastrointestinal:	☐ diarrhea ☐ constipation ☐ vomiting ☐ abdominal pain ☐ heartburn ☐ jaundice
Neurological:	☐ frequent headaches ☐ seizure
Psychiatric:	☐ anxiety ☐ depression ☐ change in behavior ☐ hyperactive behavior ☐ easily distracted
Genitourinary:	☐ urinating often ☐ nighttime bedwetting ☐ painful urination
Musculoskeletal:	☐ muscle pain ☐ joint pain ☐ back pain
Hematological:	☐ unexplained bruising
Immunological:	☐ allergic reaction

PHYSICIAN AND STAFF ONLY: ☐ All other systems were reviewed and found to be negative

For checked items, please explain: _____

List all medical problems: _____

Conditions: _____

Surgeries: _____

Hospitalizations: _____

Allergies: _____

Medications: _____

Birth History

What was the patient's birth weight? _____ pounds

Was mom ill during pregnancy? ☐ Yes ☐ No

Was the baby born on time? ☐ Yes ☐ No *If no, how early or late was the baby?* _____

Did the patient have jaundice after birth? ☐ Yes ☐ No

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Family History

Diabetes	☐ Yes ☐ No	If yes, who? _____
Thyroid problems	☐ Yes ☐ No	If yes, who? _____
Heart attack or stroke before age 55?	☐ Yes ☐ No	If yes, who? _____
High cholesterol?	☐ Yes ☐ No	If yes, who? _____
How tall is the biological mother?	_____	How tall is the biological father? _____

Social History

Have you or anyone in your home experienced acts of physical or emotional harm in the last year? ☐ Yes ☐ No

Do you feel unsafe in your home? ☐ Yes ☐ No

Who lives at home? _____

Are there major financial stressors or other sources of stress at this time in your household? ☐ Yes ☐ No

Are there any smokers in the family? ☐ Yes ☐ No

What grade is your child in? _____

How is school performance? ☐ Above average ☐ Average ☐ Below average

For patients with diabetes only.

Which therapies does your child use? Check all that apply. ☐ syringe injection ☐ insulin pens ☐ insulin pump ☐ CGM

How many school days were missed due to illness in the last year? ☐ 0-10 days ☐ 11 or more days

Timing

On average, how many times a day are blood sugar checks done? ☐ 0 ☐ 1-2 ☐ 3-4 ☐ 5 or more

What times of day is blood sugar checked? ☐ before meals ☐ bedtime ☐ overnight ☐ other _____

Who checks the blood sugar? Check all that apply. ☐ child ☐ parent ☐ sibling ☐ grandparent ☐ nurse ☐ other _____

Is insulin given before or after meals? ☐ before meals ☐ after meals

Severity

Does your child recognize symptoms of low blood sugars? ☐ Yes ☐ No

About how often does your child have readings below the target range? ☐ once a month ☐ once a week ☐ once a day ☐ more than once a day

Is there an unexpired glucagon kit at home? ☐ Yes ☐ No

About how often does your child have readings above the target range? ☐ rarely ☐ a few times a week ☐ about once a day ☐ several times a day

When do you check your child for ketones? ☐ sick days ☐ blood sugar above _____ ☐ nausea/vomiting ☐ other _____

Has your child had ketones since the last visit? ☐ Yes ☐ No

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Location

Where are injections given (or infusion sets for the insulin pump)? Check all that apply.	☐ buttocks ☐ legs ☐ stomach ☐ arms ☐ other _____
Who gives the injections (or places infusion sets for the insulin pump? Check all that apply.	☐ child ☐ parent ☐ sibling ☐ grandparent ☐ nurse ☐ other _____
Have you noticed any lumps at the injection sites (or infusion sites for the insulin pump)?	☐ Yes ☐ No
Has your child had any of the following at the injection sites (or infusion sites for the pump)?	☐ leaking ☐ bleeding ☐ discomfort

_____ _____

Signature of Patient/ Legally Authorized Representative | Date & Time

_____ _____

Printed Name of Patient/Legally Authorized Representative | Relationship to Patient

For Provider to Fill Out: ROS, PMH, FMH, SOC, Hx reviewed:

_____ _____ _____

Practitioner Signature | Date | Time

_____

Printed Name