

Endocrinology

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Dear Parent,

Soon we will be evaluating your child in the Pediatric Endocrine Clinics of Cincinnati Children's Hospital Medical Center. There are several things that should be done ahead of time in order for us to provide the best care possible.

Please help us by doing the following:

- Complete the enclosed questionnaire and return it by mail in the envelope provided or fax it to (513) 636-7486 or you can access the patient questionnaire at our website <http://www.cincinnatichildrens.org/svc/alpha/e/endocrinology/default.htm>
- Due to privacy laws, we are unable to obtain your child's medical records. Please request your child's medical records from the primary physician and any other doctors involved in your child's care. These may be mailed or faxed.

Please be aware that:

➤ **Most clinics have waiting lists for new patients. If you are unable to keep the appointment, please cancel right away and reschedule by calling (513) 636-0669.**

- Physicians in training frequently attend our clinics. Your child may see one of these individuals during the visit, but one of the pediatric Endocrine Faculty will evaluate your child and answer your questions.

If you have any questions, please feel free to call the Endocrinology office at (513) 636-4744 or toll free at 1-800-344-2462.

Sincerely,

Pediatric Endocrinology Staff

PEDIATRIC ENDOCRINOLOGY CLINIC QUESTIONNAIRE

The Pediatric Endocrinology Clinic at Cincinnati Children's Hospital primarily evaluates conditions that involve too much or too little amount of one or more hormones in the body. In order to make your clinic appointment as efficient and complete as possible, please fill out this questionnaire and mail (at least 7 days before appointment), FAX to 513-636-7486 or email to endocrinology@cchmc.org at least 3 days before appointment. If it is impossible to send it in advance, please bring it with you to clinic.

Division of Endocrinology
Cincinnati Children's Hospital Medical Center
3333 Burnet Avenue, ML 7012
Cincinnati, OH 45229-3039
FAX 513-636-7486

Appointment Date _____
Appointment Time _____
Physician _____
Location _____

I. IDENTIFYING INFORMATION:

Today's Date: _____

Child's Name _____ Nickname: _____

Child's date of birth: _____ Child's age: _____ Child's sex: _____

Person filling out this questionnaire: _____ Relationship to child: _____

II. REFERRAL INFORMATION (We will send a report to the referring physician and the child's regular physician):

Self referred: OR Referred by: _____

Address: _____ Phone: _____

Child's primary physician (if different than above): _____

Address: _____ Phone: _____

III. FAMILY INFORMATION:

Child lives with: Biological Mother, Adoptive Mother, Stepmother, Other _____

Name: _____ Occupation: _____

Biological Father, Adoptive Father, Stepfather, Other _____

Name: _____ Occupation: _____

IV. REASON FOR EVALUATION: Family Concern Physician Concern Both

For what reason did you bring your child to the Endocrinology Clinic? _____

Do you have any concerns that you would rather discuss when your child is not in the examination room? _____

When was the problem that you are coming for first noticed? _____

Has any other evaluation been performed, and if so where? _____

If so, please request that the records of this evaluation be sent to our clinic.

VII. MEDICAL HISTORY:

Please check any medical conditions which apply to your child, and the age when they began:

	Condition	Age
Allergies	<input type="checkbox"/>	
Asthma	<input type="checkbox"/>	
Cleft lip	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	
Diarrhea/Constipation	<input type="checkbox"/>	
Ear Infections	<input type="checkbox"/>	
Eating Problems	<input type="checkbox"/>	
Headaches	<input type="checkbox"/>	
Hearing Problems	<input type="checkbox"/>	
Heart Problems/murmur	<input type="checkbox"/>	
High Blood Pressure	<input type="checkbox"/>	

	Condition	Age
Meningitis	<input type="checkbox"/>	
Mental Retardation	<input type="checkbox"/>	
Learning Disabilities	<input type="checkbox"/>	
Hyperactivity	<input type="checkbox"/>	
Head Injury	<input type="checkbox"/>	
Seizures	<input type="checkbox"/>	
Kidney Bladder Problems	<input type="checkbox"/>	
Low Blood Pressure	<input type="checkbox"/>	
Vision Problems	<input type="checkbox"/>	
Stomach cramps/bloating	<input type="checkbox"/>	
Unconsciousness	<input type="checkbox"/>	

Other conditions: _____

Hospital admissions or injuries date: _____ reason: _____

date: _____ reason: _____

date: _____ reason: _____

allergies: _____

medications: _____

VIII. SCHOOL:

Current grade level: _____ School performance: _____ Special education/Resource classes: _____

IX. FAMILY HISTORY:

Biological Mother: _____ Age: _____

Present height _____ Present weight _____ Age at first menstrual period: _____ Late or Early bloomer?

Any health problems? _____

Biological Father: _____ Age: _____

Present height _____ Present weight _____ Age when started shaving: _____ Age when stopped growing: _____

Late or Early bloomer? Any health problems? _____

Siblings:

<u>Name</u>	<u>Age</u>	<u>Sex</u>	<u>Ht.</u>	<u>Wt.</u>	<u>Medical Problems</u>
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Diseases that run in the family:

<u>Disease</u>	<u>Mother's side</u>	<u>Father's side</u>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
Obesity	<input type="checkbox"/>	<input type="checkbox"/>
Growth problems	<input type="checkbox"/>	<input type="checkbox"/>
Genital	<input type="checkbox"/>	<input type="checkbox"/>

Other: _____

Please call the office at (513) 636-4744 if you will be unable to keep your appointment.