UofL Physicians
PEDIATRIC ENDOCRINOLOGY

Established Patient - Endocrinology

CLINICAL INTAKE SHEET PATIENT NAME: _____ DOB: _____

Please complete the below questions to the best of your ability.

We ask all patients 10 years or older to try to complete as many questions as possible without help from parents.

What is the main reason for the visit today? _____

Who is with the patient for the visit today? _____

Review of Systems:

Please √ check all symptoms below that the patient is currently experiencing:

- ☐ Fever
- ☐ Eye Pain
- ☐ Earache
- ☐ Nosebleeds
- ☐ Chest Pain
- ☐ Cough
- ☐ Constipation
- ☐ Stomach Pain
- ☐ Joint Pain
- ☐ Eczema
- ☐ Thinning Hair
- ☐ Painful Periods
- ☐ Bedwetting
- ☐ Bruises Easily
- ☐ Seizures
- ☐ Fatigue
- ☐ Eye Redness
- ☐ Sore Throat
- ☐ Freq. Ear Infections
- ☐ Heart Beats Too Fast
- ☐ High Blood Pressure
- ☐ Shortness of Breath
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Joint Swelling
- ☐ Dry Skin
- ☐ Excess Hair Growth
- ☐ Irregular Periods
- ☐ Excessive Thirst
- ☐ Behavior Problems
- ☐ Bleeds Easily
- ☐ Dizziness
- ☐ Recent Weight Loss
- ☐ Vision Problems
- ☐ Difficulty Swallowing
- ☐ Trouble Hearing
- ☐ Heart Beats Too Slow
- ☐ Sleep Problems
- ☐ Wheezing
- ☐ Nausea
- ☐ Poor Appetite
- ☐ Joint Stiffness
- ☐ Acne
- ☐ Early or Late Puberty
- ☐ Date of Last Period: ____
- ☐ Excessive Urination
- ☐ Receives Therapy
- ☐ Anemia
- ☐ Headache/Migraine
- ☐ Recent Weight Gain
- ☐ Wears Contacts/Glasses
- ☐ Hoarseness
- ☐ Poor Sense of Smell
- ☐ Palpitations
- ☐ Snoring
- ☐ Vomiting
- ☐ Limb Pain
- ☐ Rash
- ☐ Cold/Heat Intolerance
- ☐ Growth Concerns
- ☐ Special Learning Needs

Medications:

Please list all medications that the patient is currently taking.

Med: _____ Dose: _____ # Times Daily: _____
Med: _____ Dose: _____ # Times Daily: _____
Med: _____ Dose: _____ # Times Daily: _____
Med: _____ Dose: _____ # Times Daily: _____
Med: _____ Dose: _____ # Times Daily: _____
Med: _____ Dose: _____ # Times Daily: _____
Med: _____ Dose: _____ # Times Daily: _____
Med: _____ Dose: _____ # Times Daily: _____

Allergies:

Please list all environmental, food, and medication allergies.

_____
_____
_____

Provider/Team Notes Only

Age: _____ years _____ months

Last Visit:
Date_____ with _____
Height _____ in _____ cm
Weight _____ lbs _____kg
HgbA1C _____
AvgBG _____

Vitals:
Height _____ in _____cm
Weight _____lbs _____kg
BP _____ P _____
Head Circum _____

Patient Portal?

Refills Needed?

Medication Allergies?

COMPLETE BACK PAGE

601 S. Floyd Street, Suite 403 • Louisville, KY 40202
p | 502-588-3400 • f | 502-588-3401

UofL Physicians
PEDIATRIC ENDOCRINOLOGY

Past Medical History:
Any changes to the patient's current medical problems? ☐Yes ☐No
If yes, please list: _____

Surgical History:
Any recent surgeries? ☐Yes ☐No
If yes, please list: _____

Family History:
Any changes to the patient's family medical history? ☐Yes ☐No
If yes, please list: _____

Social History:
What grade is the patient in at school? _____ School: _____

How well is the patient doing in school? ☐Excellent ☐Good ☐Fair ☐Poor

Any activities or sports? (please list) _____
_____

Any family stressors?
_____
_____

Any changes to the patient's social history? ☐ Yes ☐ No
If yes, please list: _____

Provider/Team Notes Only

Does the patient smoke?

Has the patient ever smoked?

Attach U/A (if applicable):

Recent Labs/Xrays?

Recent Hospitalization?

601 S. Floyd Street, Suite 403 • Louisville, KY 40202
p | 502-588-3400 • f | 502-588-3401