UofL Physicians
PEDIATRIC ENDOCRINOLOGY

New 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: _____

Allergies:

Please list all environmental, food, and medication allergies.

_____

Birth History:

Birth of Patient: ☐ On Time ☐ Early(___wks) ☐ Late(___wks)

Size at Birth: Weight _____ pounds / Length _____ inches

Delivery Type: ☐ Natural ☐ C-Section ☐ Used Forceps

Breech Birth (feet first)? ☐ Yes ☐ No

Problems after delivery?

☐ None ☐ Low Blood Sugar ☐ Other: _____
☐ Seizures ☐ Oxygen Needed

Problems during pregnancy?

☐ None ☐ Toxemia ☐ Used Drugs ☐ Smoked
☐ Early Labor ☐ Gest. Diab. ☐ Used Alcohol ☐ Infection

Provider/Team Notes Only

Age: _____ years _____ months

Previous Endo Visit?:
Date_____ with _____

Patient Portal?

Refills Needed?

Medication Allergies?

Recent Labs/Xrays?

Recent Hospitalization?

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COMPLETE BACK PAGE

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

Past Medical History:

List all past and current medical problems: _____

_____

_____

Is the patient up to date on all immunizations? ☐ Yes ☐ No

Has the patient received a flu vaccine in the last year?

☐ Yes ☐ No, but will ☐ No, will not

Surgical History:

List all surgeries the patient has had: _____

_____

_____

Family History:

List any medical problems in the family:

Problem: _____ Who: _____

Problem: _____ Who: _____

Problem: _____ Who: _____

Problem: _____ Who: _____

Problem: _____ Who: _____

Problem: _____ Who: _____

Problem: _____ Who: _____

Does anyone else in the family have the same problem as the patient?

_____

Social History:

Please give information on the immediate family members in the home below.

Name	Age	Height	Weight	Relationship to Patient

Parent(s) are ☐ single ☐ married ☐ divorced ☐ separated ☐ deceased

Who has custody of the patient? _____

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? _____

Provider/Team Notes Only

Vitals:

Height _____ in _____cm

Weight _____lbs _____kg

BP _____ P _____

Head Circum _____

Attach U/A (if applicable):

Does the patient smoke?

Has the patient ever smoked?

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UofL Physicians

GENERAL CONSENT FORM

PATIENT NAME: _____ Date of Birth: _____

Payment. I authorize University of Louisville Physicians, Inc. (UofL Physicians) to submit claims on my behalf directly to Medicare/Medicaid/my private health insurance carrier. This means that UofL Physicians will direct payment for supplies and services provided. I understand that I am financially responsible to the provider(s) for the charges not paid or payable. I authorize you to release any information necessary to insurance carriers regarding illnesses and treatment to process claims.

Initials: _____

Consent for Treatment. I consent for UofL Physicians to administer treatments, tests and/or diagnostic tests to treat my/the patient's injury/illness on an outpatient basis. I acknowledge there is no guarantee as to the outcome of any treatment I/the patient receives. In compliance with state law, as part of the care to be given a test may be performed for human immunodeficiency virus infection (HIV/AIDS), hepatitis, or other blood-borne infectious or communicable diseases if the doctor, APRN, or Physician Assistant orders the test for diagnostic purposes because of my/the patient's medical history, symptoms, or conditions.

Initials: _____

Electronic Prescription. I understand UofL Physicians utilizes electronic prescribing technology and participates with SureScripts. SureScripts operates the Pharmacy Health Information Exchange, which facilitates the electronic transmission of prescription information between providers and pharmacists. SureScripts also provides prescription data on any medications, known as medication history, which are prescribed to me/the patient. Initials: _____

Cell Phone Calls/Text and Emails. As a service to our patients, we provide a courtesy appointment reminder calls/text and possibly other important calls that may be placed using a prerecorded message. By providing your cell phone number, you consent to receiving such calls at this number. By providing your email address you acknowledge that you may receive health care surveys and other health care related communications. You understand this is not to be used for provider communication and that email is not secure and can be intercepted and used by unauthorized persons.

Involvement of Others in Care. I authorize UofL Physicians to provide and discuss my/the patient's care and medical needs with the following persons:

Name	Date of Birth	Relationship	Phone

Patient Rights and Responsibilities

I acknowledge receipt of the Patient Rights and Responsibilities _____ Declined_____

Notice of Privacy Practices

I acknowledge receipt of the Notice of Privacy Practices _____ Declined_____

Minor Patient Photograph

I consent for UofL Physicians to photograph the patient for identification purposes only_____ Declined_____

_____ _____

Patient/Parent/Legal Guardian/Legal Authorized Representative Signature **Date**

If Parent/Legal Guardian/Legal Authorized Representative, Print Name _____