The Children's Hospital
AT SAINT PETER'S UNIVERSITY HOSPITAL
A MEMBER OF SAINT PETER'S HEALTHCARE SYSTEM

Saint Peter's University Hospital Pediatric Specialty Service
Pediatric Endocrinology Department
254 Easton Avenue, 3rd Floor MOB, New Brunswick, New Jersey 08903

Please ask your primary care provider (PCP) to fax the following information to732-514-1956 for the doctor to review. We recommend that you bring a copy to the visit too:

- ☐ All previous heights and weights and growth charts (ESSENTIAL)
- ☐ Medical records
- ☐ Laboratory test results
- ☐ Radiology (X-rays, ultrasounds, etc.) reports
- ☐ Radiology films or CD (they must be requested by the parent/guardian)
- ☐ First Interview Visit Form completed by parent/guardian (attached). Once complete, you can fax it to 732-514-1956 or email it to pedsendo@saintpetersuh.com. Please bring a copy to the visit too in case we did not receive them directly.

Please bring the following information for registration:

- ☐ Referring PCP's name, address and phone number (attached)
- ☐ Insurance identification card(s)
- ☐ Identification of parent / guardian. All children under the age of 18 must be accompanied by a parent or legal guardian
- ☐ HMO recipients, please bring a referral for office visit or
  PPO recipients, please bring a prescription from PCP
- ☐ Diabetes self-management education referral for certified diabetes educator and nutrition visit
- ☐ If applicable, a referral for laboratory services

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FIRST VISIT INTERVIEW

Name_____ Age_____ Referred by_____

Unit Number_____ Date of Birth_____ Date of Visit_____

Please complete Questionnaire:

Why was your child referred to our office?:_____

How long has your child had this problem?:_____

Are there any other symptoms or complaints?:_____

Has your child experienced any of the following:

PROBLEMS	No	YES	If YES PLEASE DESCRIBE
Headaches			
Dizziness			
Passing out			
Seizure			
Vision problems			
Hearing problems			
Trouble smelling things			
Trouble breathing			
Wheezing			
Heart murmur			
Hot or Cold when other people are not			
Sleep Problems			
Urinating (peeing) a lot			
Drinking a lot			
Bed wetting			
Poor appetite			
Vomiting			
Abdominal Pain			
Constipation			
Diarrhea			
Bruising a lot			
Bleeding a lot/Bleeding problem			
Anemia			
Joint Pain			
Broken bones			
Other:			

Dietary Intake (Pease complete attached food log if your child is being referred for **diabetes or growth**)

How would you describe your child's eating habits?:_____

How would you describe your child's personality?:_____

School Grade:_____

How is your child doing in school:_____

Past Medical History (circle or fill in the blanks):

Born Full Term or Premature?: (_____ weeks) Normal Vaginal Delivery / Caesarean Section:

Was the pregnancy normal or complicated (describe)?:_____

Did Mom take any medications during pregnancy?:_____

Were there any problems during delivery?:_____

Birth Weight_____pounds _ ounces Length_____ inches

Any problems in the nursery?:_____

Your child was born at_____Hospital. Length of stay_____

How old was your child when he / she:

sat without support _____ walked_____ talked_____

has first tooth _____ permanent teeth_____

Did your child have any hospitalizations, surgeries or significant illnesses in the past?:

_____

_____

_____

Age when he / she developed

Breasts_____ Pubic Hair_____ Axillary hair_____ Menses_____
None of the above_____

Is he / she taking any medications? (If yes, please list):_____

_____

Does your child have any allergies to medication (Y / N) If yes, please list:

_____

Family History	Age	Height	Weight	Health	Age of Puberty
Father					
Mother					
Sibling #1					
Sibling #2					
Sibling #3					
Paternal Grandfather					
Paternal Grandmother					
Maternal Grandfather					
Maternal Grandmother					

Is there anyone in the family with diabetes, thyroid problems, growth problems, or any other significant medical problem? If yes, please explain:

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PEDIATRIC SPECIALTY SERVICES
Division of Pediatric Endocrinology
Third Floor - Medical Office Building
254 Easton Avenue
New Brunswick, New Jersey 08901
Office Number: (732) 745-8574
FAX Number: (732) 514-1956

PRIMARY CARE PROVIDER INFORMATION

Name of Child:_____ Medical Record Number_____

Name of Group:_____

Name of Primary Care Provider:_____
(First name) (Last name)

Street Address _____

_____

Phone Number _____

FAX Number _____

ANY CHANGES REGARDING YOUR CHILD'S PRIMARY CARE PROVIDER SHOULD BE REPORTED IMMEDIATLEY TO OUR OFFICE!

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What Does Your Child Eat?

IF your child is being referred for <u>diabetes or growth</u>, it is important for us to know exactly what your child eats so that we can assess the calories, protein and overall nutrient. This is especially important if you child is not gaining weight properly, therefore, we need to determine the cause.

Please record all foods and beverages that your child takes throughout 3 typical days of eating and drinking. Include all beverages, night time bottles and all meals / snacks. Do not record any days when your child is ill.

Under the comment section, please record information such as refusal to eat, nausea, vomiting, did not tolerate, diarrhea, and activity that may have an impact on what was eaten.

<u>RECORD FOR 3 FULL DAYS.</u>

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Patient Name:_____ Unit Number:_____

DAY ONE			
Date / Time	Food	Amount	**Comment**

DAY TWO			
Date / Time	Food	Amount	**Comment**

DAY THREE			
Date / Time	Food	Amount	**Comment**