



Patient's Name: \_\_\_\_\_

Age: \_\_\_\_\_

Account No. \_\_\_\_\_

DOB: \_\_\_\_\_

Emergency Contact Name & Telephone: \_\_\_\_\_

**Child's Health History**

PLEASE PRINT

**Chief Complaint/ Reason for visit:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Past Medical History:**

*(Please list all medical problems and approximate dates of onset)*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Previous Hospitalizations, date and reason:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Birth History**

Pregnancy: \_\_\_\_\_ Delivery mode: Vaginal \_\_\_\_\_ Cesarean \_\_\_\_\_

Birth weight: \_\_\_\_\_ Birth Length: \_\_\_\_\_

Breast or Bottle fed: \_\_\_\_\_ Vaccinations: \_\_\_\_\_

Diabetes & Glandular Disease Clinic, P.A.

Patient's Name: \_\_\_\_\_

**Medications**

<u>Name</u>	<u>Dosage</u>	<u>Date Started</u>	<u>What Condition</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Allergies:**

Drug: \_\_\_\_\_

Food: \_\_\_\_\_

**Social History**

Pre-school, kindergarten or school \_\_\_\_\_ Grade: \_\_\_\_\_

Other activities and sports: \_\_\_\_\_

Smokers in household: (Please circle one)    Yes                  No

**Family History**

Father:                  Age: \_\_\_\_\_ Height: \_\_\_\_\_ Health Condition: \_\_\_\_\_

Pubertal development: (Early, average, or late) \_\_\_\_\_

Mother:                  Age: \_\_\_\_\_ Height: \_\_\_\_\_ Health Condition: \_\_\_\_\_

Age at first menstrual period \_\_\_\_\_

Health condition of siblings and other family members: \_\_\_\_\_

Diabetes & Glandular Disease Clinic, P.A.

**Patient's Name:** \_\_\_\_\_

**Review of Body Systems**

(Please Print)

**Please list any problems relating to the following:**

**Growth and weight gain, appetite:** \_\_\_\_\_

**Energy level, heat/cold tolerance:** \_\_\_\_\_

**Skin:** \_\_\_\_\_

**Ears, nose and throat:** \_\_\_\_\_

**Vision:** \_\_\_\_\_

**Neck:** \_\_\_\_\_

\_\_\_\_\_

**Chest, lung, and heart:** \_\_\_\_\_

**Abdomen:** \_\_\_\_\_

**Nervous system (headache, balance, gait):** \_\_\_\_\_

\_\_\_\_\_

**Urinary and bowel:** \_\_\_\_\_

\_\_\_\_\_

Diabetes & Glandular Disease Clinic, P.A.

**Patient's Name:** \_\_\_\_\_

**Menstrual Periods:**

**Age at onset:** \_\_\_\_\_ **Frequency** \_\_\_\_\_ **Length** \_\_\_\_\_

**Date of last period:** \_\_\_\_\_

**Sexually active: (Please circle one)**    **Yes**    **No**

**Behavioral:**

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## **Important Information for Patients**

### **Laboratory Test Results**

- ❖ **If you have tests performed in our laboratory, most results will be mailed to you within five to seven days. Some reference tests may take as long as 30 days.**
- ❖ **If you would like to discuss your tests after receiving the mailed results, please schedule an appointment with one of our Nurse Practitioners or your Physician if necessary. As part of our commitment to excellent patient care, we will not discuss the lab results over the telephone. We believe that it is in the best interest of our patients to have a scheduled time in our office to discuss any test results.**
- ❖ **If it is necessary for us to inform you of results that might require immediate attention, we will contact you by telephone.**

### **Bone Density Results**

- ❖ **Results of Bone Density test will be mailed to you within five to seven days.**

### **Biopsy and Ultrasound Results**

- ❖ **It is necessary to schedule an appointment with your doctor one week following your biopsy or ultrasound. Results will be discussed during this appointment.**

## **Important Information Regarding Prescriptions**

- ❖ **Please be sure to ask for a six (6) month prescription from your doctor before you leave the clinic.**
- ❖ **You must submit your written prescriptions that we have provided you at the time of your appointment to the pharmacy of your choice to be filled.**
- ❖ **Once you are an established patient, refill prescriptions may be taken to the pharmacy of your choice or we will fax results refills only to HEB pharmacies.**
- ❖ **To make sure that you get the right kind and dose of medications we feel that a written prescription is the best and safest way of ensuring your health.**
- ❖ **Prescriptions will not be renewed over the phone. If the number of refills on your prescription expires before your next appointment with us, please call our main number at (210) 614-8612 or toll free at 1-800-373-4021 and ask for the Pediatrics Prescription Line to request a new prescription. You may come by our clinic to pick up your prescription or we can mail it to you within five days.**
- ❖ **The Pediatrics Prescription Line hours are Monday 8:30 A.M. to 11:30 A.M. and Tuesday through Friday, 8:30 A.M. to 4:00 P.M.**