UF ENDOCRINOLOGY, DIABETES AND METABOLISM AT EMERSON

Please complete this questionnaire to enhance your visit.

University of Florida College of Medicine-Jacksonville

ENDOCRINOLOGY, DIABETES AND METABOLISM CLINIC

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ADOLESCENT HEALTH QUESTIONNAIRE

Appointment Date:	
Name:	Date of birth:
FATHER: MOTHER:	Guardian:
Referring Doctor: Address: Telephone number:	

What specific questions do you have?

_____

FAMILY HISTORY:

M other's Height: Age of first period

Father's Height: Growth spurt

Please indicate with a check (√) any family members on either side who have had any of the following:

MEDICAL PROBLEMS	MOTHER'S SIDE	FATHER'S SIDE
Mental Retardation		
Learning Disabilities/problems		
Seizures		
Headaches		
Genetic Disorders		
Thyroid problems		
Diabetes		
Being overweight		
Early puberty		
Delayed puberty		
Premature fractures broken bones		
Kidney stones		
Other medical problems		

Pregnancy, Delivery and Birth:

Please complete this questionnaire to enhance your visit.

During pregnancy, mother… (check all that apply and describe)
o Drank alcohol or used drugs
o Smoked
o Suffered any illness, infection, trauma, fevers
o Took medication (which?)
o Had other significant events occur

During labor and delivery, mother and/or baby… (check all that apply and describe)
o Suffered fetal distress
o Suffered complications (breech birth, cord around neck, lack of oxygen, Csection, forceps, required oxygen, etc.)
o Required special care (ICU, incubator, etc.)

Length of pregnancy weeks: Baby's weight lbs oz

Developmental History:

At what age did the child: Walk alone: Say first word: Speak in sentences:

Please indicate if the child suffered any of these problems as an infant or young child and describe:
o Delayed development or growth
o Aggression (hitting, biting, kicking)
o Difficulty making or keeping friends
o Shunned by peers
o Defiance, resistance to authority

School History:

Child began school at age: Current grade:

Describe the child's grades junior high school: in high school:

Medical History:

Please indicate and describe the child's current and past health problems:
Age and duration Treatment
o Headaches, Seizures, Head injury, Loss of consciousness
oMeningitis, Encephalitis, Brain tumor
o Paralysis
o High fever
o Fainting spells
o Coma
o HIV infection/AIDS
o Near drowning
o Electric Shock
o Drug/alcohol abuse

Please complete this questionnaire to enhance your visit.

I. Additional history or conditions now or in the past? Please include any broken bones and transfusions. (Use additional sheets as needed.)

Condition	Date	Treatment(s)	Hospital

II. Please list all hospitalizations and surgeries

Surgery	Date	Problems afterward?	Hospital

III. Please list all medications that are prescribed, including injections, herbal medicine, supplements and vitamins you take.

Medications	How many times a day?	How many units or milligrams?	Reason

Please complete this questionnaire to enhance your visit.

IV. Please list medicines or dyes AND the reactions you have to them.

_____

_____

V. PERSONAL HISTORY (Please circle or fill in the best answer.)

Do you smoke cigarettes, pipe or cigars? Yes / No How many in one week?
Do you drink any wine, beer or spirits? Yes / No How many at one time?
What exercise do you get regularly? How many minutes a week?
Do you have a job?

VII. SYMPTOMS: **Circle** any and all symptoms you have presently.
Weight loss, Weight gain. Fever, Chills, Night sweats.
Low energy level, Difficulty sleeping, Loss of hearing
Blurry vision, Vision loss, Dry eyes, Tunnel vision, Double vision
Chest pain, Leg swelling. Heart pounding, Heart murmur
Shortness of breath, Coughing, Wheezing .
Change in voice, Difficulty swallowing, Lump in neck
Nausea, Vomiting, Heartburn, Diarrhea, Constipation, Abdominal pain.
Headaches, Memory change. Numbness, tingling or burning sensation.
Muscles aches, Muscle cramps, Muscle weakness, Poor balance
Joints aches. Swollen joints, Changes in nails, Shaking tremors
Depression, Easy irritability Nervousness. Nightmares
Heat or cold intolerance. Goiter, Feeling thirsty Feeling hungry
Trouble passing urine, Blood in urine Urinating at night
Abnormal hair growth, Abnormal hair loss
Rashes, Easy bruising. Swollen lymph glands, Height Loss
For women

How old when starting menstrual cycles?
Was there ever a time they stopped for > 12 months? Yes / No
Have they stopped? Yes /No. How old were you at the time?____