Children's SM Physician Group

Please complete the following documents and bring to your appointment. The clinical staff will collect this from you.

Thank you!

Por favor complete los siguientes documentos y tráigalos a su cita. El personal clínico le pedirá estos documentos.

Gracias!

20425-01

2-Hole 1/4 2 3/4 c-to-c

3-Hole 1/4 4 1/4 c-to-c

Children's Physician Group - Endocrinology and Diabetes
Children's Specialty Services

Endocrinology and Diabetes Home Medication Reconciliation Form

Name_____

Date of Birth_____

MRN#_____

Account/HAR#_____

PATIENT IDENTIFICATION

Dear Patient, Parent, or Guardian:

Please list current medications your child is taking. This will allow us to have a complete list for consideration when choosing medications for your child today.

PLEASE BRING ALL MEDICATIONS IN ORIGINAL CONTAINER TO EACH VISIT.

Does your child have any allergies to medicines? ☐ No ☐ Yes If "Yes", please list the medication and type of reaction below:

Name of Medication	What happens when your child takes it?
	☐ Rash ☐ Hives ☐ Swelling ☐ Vomiting ☐ Other _____
	☐ Rash ☐ Hives ☐ Swelling ☐ Vomiting ☐ Other _____
	☐ Rash ☐ Hives ☐ Swelling ☐ Vomiting ☐ Other _____
	☐ Rash ☐ Hives ☐ Swelling ☐ Vomiting ☐ Other _____

Please list all of your child's current medicines. ☐ **My child is not on any medicines right now.**

DO NOT INCLUDE INSULIN

Medicine (oral & injectable) Please list the name of each medicine your child takes	**How much does your child take?** Such as 2 ml, 5 mg, or 1 tsp.	**How often does your child take it?** Such as once a day, twice a day	**How does your child take this medication?** Such as by mouth or ear drops	**Why does your child take this medicine?**	**When was the last dose of this medication given?**

Source of information: ☐ Patient ☐ Parent ☐ Guardian ☐ Other

Pharmacy name: _____ Pharmacy phone number: _____

I have reviewed the list above.

_____ _____

Signature (Parent/Legal Guardian/Patient) Date/Time

_____ _____

Signature (Nurse/Physician/Provider) Date/Time

34474-08

Children's Physician Group
Endocrinology

GENERAL INTAKE QUESTIONNAIRE
CUESTIONARIO GENERAL PARA PACIENTES NUEVOS

Name_____

Date of Birth_____

MRN#_____

Account/HAR#_____

PATIENT IDENTIFICATION

Dear Parent:
Estimado padre/madre:

Thank you for allowing us to care for your child. If you are receiving this form via email or mail, please complete it before your visit. If you have received this form on the day of your visit, please complete this form as you wait and let registration know once finished.
Muchas gracias por permitirnos atender a su hijo/hija. Si recibió este formulario por correo electrónico o correo postal, por favor complételo antes de su visita. Si lo recibió el día de su visita, por favor complételo mientras esperan ser atendidos y avísele a la persona encargada de registros una vez que haya terminado.

Please check all that apply when answering the questions below:
Por favor, marque todo lo que corresponda al responder las preguntas que aparecen a continuación:

1. **Does the patient have any of the following general issues?**
¿El/la paciente tiene alguno de los siguientes problemas?

☐ **No problems** No tiene problemas ☐ **Weight change** Cambios en el peso ☐ **Fatigue (lack of energy)** Fatiga (falta de energía) ☐ **Sleep problems** Problemas de sueño ☐ **Fever** Fiebre ☐ **Other** Otro

2. **Does the patient have any problems with his/her eyes?**
¿El/la paciente tiene algún problema en los ojos?

☐ **No problems** No tiene problemas ☐ **Eye pain/discomfort** Dolor/molestias en los ojos ☐ **Difficulty seeing** Dificultad para ver ☐ **Wears glasses/contacts** Usa gafas/lentes de contacto

3. **Does the patient have any problems with his/her ears, nose or throat?**
¿El/la paciente tiene algún problema en los oídos, nariz o garganta?

☐ **No problems** No tiene problemas ☐ **Hearing difficulty** Dificultad para oír ☐ **Snoring** Ronca ☐ **Runny nose** Secreciones nasales ☐ **Ear infection/pain** Infección/dolor de oído

☐ **Noisy breathing** Ruido al respirar ☐ **Sore throat** Dolor de garganta ☐ **Ear pain/pulling** Dolor de oído/se jala la oreja

4. **Does the patient have heart problems?**
¿El/la paciente tiene problemas cardíacos?

☐ **No problems** No tiene problemas ☐ **Chest pain** Dolor de pecho ☐ **Irregular/skipped heart beats** Latidos irregulares/saltos en los latidos ☐ **Passing out** Desmayos

5. **Does the patient have problems with his/her breathing?**
¿El/la paciente tiene algún problema para respirar?

☐ **No problems** No tiene problemas ☐ **Cough** Tos ☐ **Difficulty breathing** Dificultad para respirar ☐ **Wheezing** Silbido al respirar

6. **Does the patient have gastrointestinal (stomach) problems?**
¿El/la paciente tiene algún problema gastrointestinal (en el estómago)

☐ **No problems** No tiene problemas ☐ **Change in appetite** Cambio en el apetito ☐ **Abdominal pain** Dolor abdominal ☐ **Diarrhea** Diarrea ☐ **Constipation** Estreñimiento

☐ **Difficulty swallowing** Dificultad para tragar ☐ **Nausea/vomiting** Náuseas/vómitos

7. **Does the patient have urinary problems?**
¿El/la paciente tiene algún problema urinario?

☐ **No problems** No tiene problemas ☐ **Painful urination** Dolor al orinar ☐ **Frequent urination** Orina con frecuencia ☐ **Blood in urine** Sangre en la orina ☐ **Bedwetting/nighttime urination** Moja la cama/orina de noche

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Children's Physician Group
Endocrinology

GENERAL INTAKE QUESTIONNAIRE
CUESTIONARIO GENERAL PARA PACIENTES NUEVOS

Name_____

Date of Birth_____

MRN#_____

Account/HAR#_____

PATIENT IDENTIFICATION

8. **What skin problems does the patient have?**
¿Qué tipo de problemas en la piel tiene el/la paciente?

☐ **No problems** No tiene problemas ☐ **Dry skin/eczema** Piel seca/eczema ☐ **Rash** Sarpullido

9. **What neurological problems does the patient have?**
¿Qué tipo de problemas neurológicos tiene el/la paciente?

☐ **No problems** No tiene problemas ☐ **Headaches** Dolores de cabeza ☐ **Weakness** Debilidad ☐ **Dizziness** Mareos ☐ **Numbness/tingling** Adormecimiento/hormigueo ☐ **Developmental delay** Retraso en el desarrollo

10. **What psychological/emotional problems does the patient have?**
¿Qué tipo de problemas psicológicos/emocionales tiene el/la paciente?

☐ **No problems** No tiene problemas ☐ **Mood changes** Cambios de humor ☐ **Behavioral problems** Problemas de conducta

11. **What bleeding/hematological problems does the patient have?**
¿Qué tipo de problemas de hemorragias/hematológicos tiene el/la paciente?

☐ **No problems** No tiene problemas ☐ **Easy bruising** Propenso a moretones ☐ **Anemia** Anemia ☐ **Swollen lymph nodes** Inflamación de los ganglios

12. **What endocrine problems does the patient have?**
¿Qué tipo de problemas endócrinos tiene el/la paciente?

☐ **No problems** No tiene problemas ☐ **Increased thirst** Aumento de la sed ☐ **Heat/cold intolerance** Intolerancia al calor/frío

13. **What musculoskeletal problems does the patient have?**
¿Qué tipo de problemas musculo-esqueléticos tiene el/la paciente?

☐ **No problems** No tiene problemas ☐ **Arm/leg pain** Dolor en el brazo/pierna ☐ **Joint swelling** Inflamación en las articulaciones ☐ **Leg swelling** Inflamación de las piernas

Please answer these general endocrine questions:
Por favor responda estas preguntas generales sobre el sistema endócrino:

1. **What symptoms/problems has the patient had?**
¿Qué síntomas/problemas ha tenido el/la paciente?

☐ **Abnormal labs** Resultados de análisis anormales ☐ **Breast development** Desarrollo de senos ☐ **Fractures (broken bones)** Fracturas (huesos rotos) ☐ **Fatigue (lack of energy)** Fatiga (falta de energía)

☐ **Galactorrhea (breast discharge)** Galactorrea (secreción de los senos) ☐ **Gynecomastia (breasts in males)** Ginecomastia (senos en hombres) ☐ **Hirsutism (increased hair growth)** Hirsutismo (aumento en el crecimiento del vello)

☐ **Hyperglycemia (high blood sugar)** Hiperglucemia (azúcar alta en la sangre) ☐ **Hypoglycemia (low blood sugar)** Hipoglucemia (azúcar bajo en la sangre) ☐ **Polydipsia (increased thirst)** Polidipsia (aumento de la sed)

☐ **Polyuria (increased urination)** Poliuria (aumento en la orina) ☐ **Irregular periods** Períodos irregulares ☐ **Micro penis (small penis)** Micropene (pene pequeño) ☐ **Obesity** Obesidad ☐ **Pituitary tumor** Tumor pituitario

☐ **Syncope (passed out)** Síncope (desmayo) ☐ **Vitamin D deficiency** Deficiencia de vitamina D ☐ **Weakness** Debilidad ☐ **Weight gain** Aumento de peso ☐ **Weight loss** Pérdida de peso

2. **How long have they had these symptoms/problems?**
¿Por cuánto tiempo ha tenido estos síntomas/problemas?

☐ **Days** Días ☐ **Weeks** Semanas ☐ **Months** Meses ☐ **Years** Años

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Children's Physician Group
Endocrinology

GENERAL INTAKE QUESTIONNAIRE
CUESTIONARIO GENERAL PARA PACIENTES NUEVOS

Name_____

Date of Birth_____

MRN#_____

Account/HAR#_____

PATIENT IDENTIFICATION

3. **Are the problems/symptoms listed above:**
Los problemas/síntomas mencionados antes:

☐ **Gone completely** Desaparecieron completamente ☐ **Better** Están mejor ☐ **The same** Siguen igual ☐ **Getting worse** Están empeorando

4. **Are medications taken for an endocrine problem?**
¿Toma medicamentos debido a un problema endócrino?

☐ **Yes** (Sí) ☐ **No**

If yes, what medications are taken for endocrine problems? _____
Si respondió que sí, ¿qué medicamentos está tomando por problemas endócrinos?

How often is a dose missed in a typical week?
En una semana típica, ¿con cuánta frecuencia se olvida de tomar una dosis?

☐ **Never miss a dose** Nunca se olvida una dosis ☐ **Less than 2 doses** Menos de 2 dosis ☐ **Less than 5 doses** Menos de 5 dosis ☐ **5 or more doses** Como mínimo 5

Parent/Guardian signature Firma del padre/madre/tutor legal	**Reviewed by** Revisado por	**Date** Fecha	**Time** Hora

For in-clinic use only

Temp	HR	RR	B/P	Wt (kg)	Ht (cm)	HC	O2 Sat

Pain Score	Pain Scale

Clinical Staff Signature: _____ Date: _____ Time: _____

34474-08

Children's Healthcare of Atlanta
Children's Physician Group

SOCIAL HISTORY
ANTECEDENTES SOCIALES

Name_____

Date of Birth_____

MRN#_____

Account/HAR#_____

PATIENT IDENTIFICATION

Dear Parent:
Thank you for allowing us to care for your child. If you are receiving this form via email or mail, please complete it before your visit. If you have received this form on the day of your visit, please complete this form as you wait and let registration know once finished.
Estimados padres:
Gracias por permitirnos atender a su hijo. Si recibe este formulario por correo electrónico o correo postal, por favor complételo antes de su cita. Si ha recibido este formulario el día de su cita, por favor complete el formulario mientras espera y cuando termine informe al registro.

Please check all that apply when answering the questions below:
Por favor, marque lo que corresponda al responder a las siguientes preguntas:

1. Patient accompanied to appointment by: (choose all that apply)
   Al paciente lo acompaña a la cita: (elija lo que corresponda)
   ☐ Mother / Madre ☐ Father / Padre ☐ Foster parents/guardian / Padres de crianza/tutor ☐ Siblings / Hermanos/as ☐ Grandparents / Abuelos
   ☐ Other / Otro _____

2. Lives with: (choose all that apply)
   Vive con: (elija lo que corresponda)
   ☐ Mother / Madre ☐ Father / Padre ☐ Siblings / Hermanos/as ☐ Grandmother / Abuela ☐ Grandfather / Abuelo ☐ Aunt / Tía ☐ Uncle / Tío
   ☐ Cousin(s) / Primo (s) ☐ Foster parent(s) / Padre (s) de crianza ☐ DFCS ☐ Other / Otro _____

3. Legal custody: (choose all that apply)
   Custodia legal (elija lo que corresponda)
   ☐ Mother / Madre ☐ Father / Padre ☐ Siblings / Hermanos/as ☐ Grandmother / Abuela ☐ Grandfather / Abuelo ☐ Aunt / Tía ☐ Uncle / Tío
   ☐ Cousin(s) / Primo(s) ☐ Foster parent(s) / Padre(s) de crianza ☐ DFCS ☐ Other / Otro _____

4. Number of siblings:
   Número de hermanos:
   ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5+ ☐ Other / Otro _____

5. Mother's occupation: _____
   Oficio de la madre

6. Father's occupation: _____
   Oficio del padre

7. Pets/Animals (choose all that apply)
   Mascotas/Animales (elija lo que corresponda)
   ☐ None / Ninguno ☐ Cats / Gatos ☐ Dogs / Perros ☐ Other / Otro _____

8. Additional activities outside of school (choose all that apply)
   Otras actividades fuera de la escuela (elija lo que corresponda)
   ☐ Sports / Deportes ☐ Arts / Arte ☐ Religious activities / Actividades religiosas ☐ Other / Otras _____

34474-08

Children's Healthcare of Atlanta
Children's Physician Group

SOCIAL HISTORY
ANTECEDENTES SOCIALES

Name_____

Date of Birth_____

MRN#_____

Account/HAR#_____

PATIENT IDENTIFICATION

9. Stressors (choose all that apply)
Factores estresantes (elija lo que corresponda)

☐ None / Ninguno ☐ Illness/Death / Enfermedad/Muerte ☐ Money / Dinero ☐ Multiple moves / Mudanzas múltiples ☐ Parents / Padres

☐ School/Bullying / Escuela/Hostigamiento escolar ☐ Transportation / Transporte ☐ Other / Otro _____

10. Grade Level
Grado escolar

☐ None / Ninguno ☐ Daycare / Guardería ☐ Medically Fragile Daycare / Guardería para niños medicamente frágiles

☐ Preschool / Pre escolar ☐ Kindergarten / kinder ☐ 1st grade / 1er grado ☐ 2nd grade / 2do grado ☐ 3rd grade / 3er grado

☐ 4th grade / 4to grado ☐ 5th grade / 5to grado ☐ 6th grade / 6to grado ☐ 7th grade / 7mo grado ☐ 8th grade / 8vo grado

☐ 9th grade / 9no grado ☐ 10th grade / 10mo grado ☐ 11th grade / 11vo grado ☐ 12th grade / 12vo grado ☐ College / Universidad ☐ Special Accommodations / Adaptaciones especiales

_____	_____	_____	_____
Parent/Guardian signature Firma del padre/tutor legal	Reviewed by Revisado por	Date Fecha	Time Hora

How are you doing with DIABETES?

Insulin

My quick acting insulin is:

❑ Humalog ❑ Novolog ❑ Apidra

At *breakfast*, I take:

1 unit for _____ g carbohydrate, about _____ total units, and _____ units Levemir, or Lantus.

At *lunch*, I take:

1 unit for _____ g carbohydrate, about _____ total units.

At *supper*, I take:

1 unit for _____ g carbohydrate, about _____ total units. and _____ units Levemir, or Lantus.

At *bedtime*, I take:

1 unit for _____ g carbohydrate, about _____ total units. and _____ units Levemir, or Lantus.

During the daytime, my high blood sugar formula is:

blood glucose - 100 divided by _____.

I give my insulin with:

❑ syringes ❑ prefilled pens ❑ cartridge pens

My syringes are: 1 cc 1/2 cc 3/10 cc
regular length short length

My insulin is injected by:

❑ me ❑ my parents ❑ other relatives
❑ school nurse ❑ clinic staff

Who calculates the insulin dose?

❑ me ❑ my parents ❑ other relatives
❑ school nurse ❑ clinic staff

I remember to rotate my injection sites between:

❑ arms ❑ abdomen ❑ front of leg
❑ side of leg ❑ back of leg ❑ buttocks

I have a blood ketone meter: ❑yes ❑no

Glucose Monitoring

In the last two weeks, I have been testing my blood sugars_____ times a day using a meter called the: _____ . Even though I am old enough to do my own testing, my parents review my blood sugars:

❑ every time ❑ weekly
❑ once a day ❑ less than weekly

I have low blood sugars:

❑ once a day ❑ once a week ❑ rarely each month

My low blood sugars usually occur when _____

_____

I take my insulin:

❑ before I eat
❑ sometimes before and sometimes after I eat
❑ after I eat

Other important parts of diabetes care

My last eye exam was on _____

My last dental check-up was on _____

School

I am in the _____ grade.

I need the following supplies (circle them):

Please send:

30 days supply -- 90 days supply

Bottles of:

Humalog - NovoLog -- Apidra -- Lantus -- Levemir

Pens for:

Humalog - NovoLog -- Apidra -- Lantus -- Levemir

Syringes:

30 units size - 50 units - 100 units

Pen needles:

Nano (4mm) - Mini (5mm) - Short (6mm)

Glucose test strips:

Aviva Plus - Aviva Nano - Freestyle -- Freestyle Lite -- One Touch Ultra - TrueMetrix -- VerioIQ

Glucagon emergency kit

Zofran nausea tablets

New meter: _____ (brand)

Other stuff to tell us:

_____

_____

_____

_____

_____

_____

How are you doing with YOUR PUMP?

Insulin

Which insulin do you use?

❑ Humalog ❑ Novolog ❑ Apidra

The amount of insulin I take:

***breakfast*:** (*pump time setting*: _____ *to* _____)

1 unit for _____ g carbohydrate, about _____ total units.

***lunch*:** (*pump time setting*: _____ *to* _____)

1 unit for _____ g carbohydrate, about _____ total units.

***supper*:** (*pump time setting*: _____ *to* _____)

1 unit for _____ g carbohydrate, about _____ total units.

***bedtime*:** (*pump time setting*: _____ *to* _____)

1 unit for _____ g carbohydrate, about _____ total units.

For high blood sugars, I take extra insulin:

(blood glucose – 100) / _____ .

Basal rates:

12MN . 2 . 4 . 6 . 8 . 10 . 12N . 2 . 4 . 6 . 8 . 10 .

My pump is: ❑ MiniMed ❑T-slim ❑Animas

Other _____

My infusion set used mostly is:

❑ Sof-set ❑ Silhouette ❑ Comfort ❑ Inset

❑ Cleo ❑ Tender ❑ Quick-set ❑ Other

My tubing is changed every:

❑ 1 or 2 days ❑ 2 or 3 days ❑ other

I rotate my pump sites between:

❑ abdomen ❑ front of leg ❑ arm ❑ buttocks

My site is changed by:

❑ me ❑ my parents ❑ other relatives

❑ school nurse ❑ clinic staff

I have a blood ketone meter: ❑yes ❑no

Glucose Monitoring

In the last two weeks, I have been testing my blood sugars_____ times a day using a meter called the: _____ . Even though I am old enough to do my own testing, my parents review my blood sugars:

❑ every time ❑ weekly

❑ once a day ❑ less than weekly

I have low blood sugars:

❑ once a day ❑ once a week ❑ rarely each month

My low blood sugars usually occur when _____

_____

_____

I take my insulin:

❑ before I eat

❑ sometimes before and sometimes after I eat

❑ after I eat

Other important parts of diabetes care

My last eye exam was on _____

My last dental check-up was on _____

I had a flu shot this year: ❑ yes ❑ no

School

I am in the _____ grade.

I need the following supplies (circle them):

Please send:

30 days supply -- 90 days supply

Bottles of:

Humalog - NovoLog -- Apidra -- Lantus -- Levemir

Pens for:

Humalog - NovoLog -- Apidra -- Lantus -- Levemir

Syringes:

30 units size - 50 units - 100 units

Pen needles:

Nano (4mm) - Mini (5mm) - Short (6mm)

Glucose test strips:

Aviva Plus - Aviva Nano - Freestyle -- Freestyle Lite -- One Touch Ultra - TrueMetrix -- VerioIQ

Glucagon emergency kit

Zofran nausea tablets

New meter: _____ (brand)

Other stuff to tell us:

_____

_____

_____

_____