

HACKENSACK UNIVERSITY MEDICAL CENTER
The MOLLY Center
For Children with Diabetes and Endocrine Disorders
First Endocrine Visit Interview



PATIENT INFORMATION

Name of patient: _____
Date of birth: _____ Age: ____yrs ____mos

Insurance Company: _____	Pharmacy name & phone #: _____
Name of policy holder: _____	Primary Care Physician (PCP): _____
ID Number: _____	PCP Address: _____
Group Number: _____	PCP Phone number: _____

Best phone number to reach parent/guardian: Day _____ Evening _____
Cell _____ Email _____ Fax _____
Is it OK to contact you via email? YES NO

Mother's Name: _____ Occupation: _____ Work#: _____
Father's Name: _____ Occupation: _____ Work#: _____

Marital status of parent(s): Single Married Divorced Separated Widow

With whom does your child live? _____
(Please list all members of household)

PATIENT CURRENT MEDICAL CONCERN

Who referred your child to our office? Pediatrician referred. Other: _____

Why was your child referred to our office? _____

How long has your child had this problem? _____

Are there any other symptoms or complaints? _____

(continued from page 1)

Names, addresses, and phone numbers of other physicians your child sees as well as the reason your child sees them:

Is your child taking any medications? (List both prescription & non-prescription, vitamins, herbal remedies, including dosage) none yes: _____

Does your child have any allergies (food, medications, or environmental)? none yes: _____

Please list all medical problems (past and present), prior history of surgeries and any hospitalizations: _____ or none

Are child's immunization up to date? Yes No Not Sure
How would you describe your child's eating habits? _____

Does your child exercise on a regular basis? No Yes Describe including #hours/day: _____

PAST MEDICAL HISTORY

BIRTH HISTORY

Full Term or Premature? (# _____ weeks)

Normal Vaginal Delivery Cesarean Section (reason) _____

Was the pregnancy? normal complicated (If complicated please describe) _____

Did Mom take any medications during pregnancy? no yes: _____

Any problems with how the baby was growing during the pregnancy? no yes: _____

Were there any problems during delivery or in the nursery? no yes: _____

Birth Weight: _____ Birth Length: _____

Name and location of hospital of birth: _____

(continued from page 2)

How long did your child stay in hospital after birth? _____days/weeks/months

Breast fed? _____ Formula fed? _____ Age that baby food was introduced _____

DEVELOPMENTAL HISTORY

Approximately how old was your baby when he/she: Sat without support: _____

Walked: _____Talked: (first words)_____ Talked: (sentences) First Tooth erupted: _____

First Tooth fell out: _____ Was there any need for Early Intervention or speech,

physical or occupational therapy? no yes:_____

PUBERTY HISTORY

Age when he/she developed: Breast _____ Pubic Hair _____ Armpit Hair: _____

First Menses (period):_____ No Changes Yet

SOCIAL HISTORY

How would you describe your child's personality? _____

What are your child's favorite/main activities? _____

Has anything upset your child recently or changed your life significantly(e.g. a death in the family, marriage or divorce, job change, etc.), or are there any other issues affecting your child? No Yes If yes, explain: _____

Ethnicity of mother's family: _____ Ethnicity of father's family: _____

Does your child have any cultural or religious beliefs that guide your healthcare decisions?

No Yes If yes, explain: _____

Grade in School _____ Name of School _____

Does your child have any special learning needs or any problems in school? No

Yes Explain: _____

Please describe your child's progress in school:

Unsatisfactory Satisfactory Very Good

Approximately how often does your child miss school due to illness? _____days/year

(continued from page 3)

FAMILY HISTORY

Please fill in all fields to the best of your ability. Please use extra space below if necessary.

	Age	Height	Weight	Medical problems (please check)							Age of puberty (first period for women)	Currently Living?
				Thyroid Problem	Diabetes/sugar	High Blood Pressure	High Cholesterol	Growth problem	Puberty/menstrual	Cancers		
Patient's Mother												
Patient's Father												
Mother's Mother (MGM)												
Mother's Father (MGF)					<input type="checkbox"/>			<input type="checkbox"/>				
Father's Mother (PGM)												
Father's Father (PGF)												
	Age	Sex M F										
Mother's brothers & sisters:						<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		
Father's brothers & sisters:						<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Patient siblings:												
Names:						<input type="checkbox"/>			<input type="checkbox"/>			
						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		
									<input type="checkbox"/>			

Comments/Extra space/Other family medical problems: _____

Is there anything else that we should know in order to best take care of your child? _____

Who is filling out this form? _____ Relation to patient: _____ Date: _____

(for office use only)

The above information was reviewed by me.
 Molly Staff signature _____ Print name: _____ MD/NP/RN Date: _____