Pediatric Diabetes
New Patient Intake Form

PROVIDENCE Children's Health

Appointment Date: _____ **Patient Name**_____

Patient's preferred name: _____ **Date of birth:** _____

Gender at birth: □ **Male** □ **Female** **Gender identity:** □ **Male** □ **Female** □ **Other:** _____

Preferred Language: _____ **Would you like an interpreter?** ____

Who is here today with the patient? _____

Name of referring or primary care doctor: _____

For Clinic Use	
Height (cm)	
Weight (kg)	

What matters to you today?

Birth History

Gestational age: □ Full Term □ Premature by _____ weeks
Birth weight: _____ Birth length: _____
Length of stay in the nursery or NICU: _____
Any health problems during or after delivery (please describe): _____

Diabetes

Date and place of diabetes diagnosis: _____
Diabetes type (please circle): Type 1 Type 2 Unknown
Previous diabetes care provider (if applicable):_____
Any diabetes related hospital stays after diabetes diagnosis: □ Yes □ No Date(s): _____
What was your last HbA1C (blood sugar) level? _____ Brand of your glucometer: _____
If you use an insulin pump, what brand is it and when did you start? _____
How often do you change pump sites? _____ Any problems with pump sites? _____
If you are on a continuous glucose monitor (CGM), what brand is it and when did you start?
_____

Other medical conditions, past surgeries or hospital stays □ NONE

_____

Current Medications

Insulin regimen (please check the one you use)

A. Long acting insulin: □ Lantus □ Basaglar □ Levemir □ Tresiba Amount and time? _____

B. Meal time insulin: □ Humalog □ Novolog □ Apidra □ Admelog You use: □ vial □ pens □ cartridges
Insulin to carb ratios, correction factors:_____
_____

C. Injection or pump insertion sites: □ Arm □ Leg □ Stomach □ Hip □ Bottom

D. Other medications, supplements, vitamins. Please include amount and how many times a day.
_____

Medication Allergies and Side Effects □ NONE

Medication	Allergic reaction or side effect
_____	_____

PLEASE FILL OUT THE BACK OF THIS FORM.

Immunizations up to date	Development or Behavioral Concerns? Please include any special services.
□ Yes □ No	□ Yes □ No. If yes, please describe:

Problems that you have on a regular bases or are going on right now. □ NONE

□ Low energy or fatigue	□ High blood pressure	□ Kidney or bladder infection
□ Sleep problems or snoring	□ Frequent diarrhea	□ Wetting or urine accidents
□ Change in appetite	□ Constipation	□ Changes in behavior
□ Change in weight	□ Belly pain	□ Depression
□ Change in vision	□ Muscle cramping	□ Anxiety
□ Glasses or contacts	□ Joint swelling or pain	□ Easy bruising or bleeding
□ Dental problems	□ Seizures	□ Salt craving
□ Late eruption of teeth	□ Headaches	□ Repeated low blood sugar
□ Ear infections	□ Early or late puberty	□ Glucagon use
□ Environmental allergies	□ Age of first period, if applicable	□ Skin irritation or changes
□ Asthma or wheezing	□ Irregular menstrual periods	□ Lumps where insulin is given
□ Chest pain or rapid heart beat	□ Excess hair or hair loss	□ Numb or tingling in feet

Family History

Relationship (circle one)	Name	Age	Height	Weight	Age of first menstrual period (if applicable)	Parent's occupation and name of employer
Parent (M/F)						
Parent (M/F)						
Sister/brother						
Sister/brother						
Sister/brother						

Using the abbreviations below, note any family history of the following health conditions:

M = Mother F= Father S = Sister B= Brother
MGM = Maternal Grandmother MGF = Maternal Grandfather
PGM = Paternal Grandmother PGF = Paternal Grandfather

Condition	Family Member	Condition	Family Member
□ Diabetes	_____	□ Heart disease	_____
□ Thyroid problems	_____	□ Cancer	_____
□ Menstrual issues	_____	□ Short stature	_____
□ High cholesterol	_____	□ Early or late puberty	_____
□ Autoimmune condition	_____	□ Obesity	_____
□ Celiac Disease	_____	□ Bone disease	_____
□ High blood pressure	_____	□ Others	_____

Social History

Who lives with the patient? _____
Parents' marital status: (circle one) : single married separated divorced other
Who cares for the patient during the day? _____
School: _____ Grade in school: _____
Academic performance: □ Above average □ Average □ Below Average
Activities/Hobbies/Sports: _____
Pets/Animals at home: □ None _____
Other issues (stresses, divorce, custody, abuse, etc.): _____

Is there anything else you would like the doctor to know about you? _____

Name and location of your pharmacy? _____