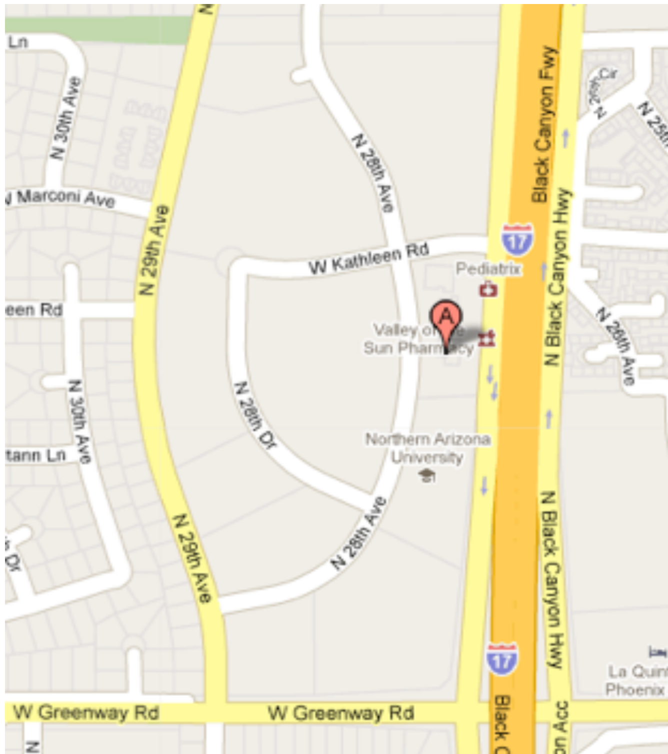
Pediatric Endocrinology of Phoenix
helping kids be kids

15600 N. Black Canyon Hwy
Suite C102, Phoenix, AZ 85053
623.748.4700 **Fax**: 602.357.3107
Email: ask@pedendophx.com
Website: www.pedendophx.com

GREETINGS,

Welcome to ***Pediatric Endocrinology of Phoenix***. Thank you for choosing us. We want to make your time with us enjoyable and productive.



We are located at: ***15600 N Black Canyon Hwy, Ste C-102, Phoenix, Arizona 85053***. You can reach us from Greenway Ave just west of I-17 by taking 29th Ave north, then take a right on 28th Ave. We are the third building on the right hand side (east) on 28th Ave. We are in the building that is furthest south. If you have any questions, please feel free to call (623) 748-4700 to reach the clinic. We look forward to seeing you!

PREPARING FOR THE VISIT

Completing this information ahead of time allows us to see you in a timely manner, and ensures we have the information necessary to fully address your health care needs.

Also enclosed is a medical records release form. Please sign this form and send it to your current physician in order for us to receive your medical records prior to your appointment. We review your records before your visit, so it is very important that we have your medical records.

PLEASE LEAVE YOURSELF PLENTY OF TIME FOR THE ENTIRE VISIT. Especially if you will also be seeing the diabetes educator or nutritionists. ***We recommend that you do not schedule anything right after the appointment to ensure you get the most out of your appointment***. For example, if you have a meeting, you may not want to schedule an endocrine appointment beforehand. We work our best to reduce wait times. Nevertheless, the appointment in total, wait time included, may last far longer than you might expect. **At minimum, set aside 1-2 hours for the entire visit.**

PLEASE BRING THE FOLLOWING ITEMS WITH YOU: this packet, ***photo ID, your insurance card(s), referral from your primary care physician if required by your insurance plan, Your copayment (if required by your plan), a list of any medications you are currently taking***

Should you need to **reschedule or cancel your appointment**, please call us at least **forty-eight (48) hours in advance** to allow us the courtesy of offering your spot to another patient.

Sincerely,
Tala Dajani M.D. M.P.H., Medical Director
Lisa Vautrin-Davis, Office Manager

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PATIENT REGISTRATION

PATIENT NAME | **DATE OF BIRTH** | **TELEPHONE NUMBER**

ADDRESS

OCCUPATION | **EMPLOYER**

EMAIL ADDRESS ***NOTE: By providing us your email address, you are giving us permission to communicate with you via email**

We ask that you give us 48-hour notice if your appointment needs to be changed or canceled. There is a $50 charge for missed and $35 charge for appointments that are canceled within the 48 hours prior to your appointment.

MOTHER'S NAME | **FATHER'S NAME**

MOTHER'S ADDRESS (if different) | **FATHER'S ADDRESS (if different)**

MOTHER'S PHONE NUMBER(S) | **FATHER'S PHONE NUMER(S)**

MOTHER'S OCCUPATION | **FATHER'S OCCUPATION**

PRIMARY INSURANCE COMPANY | **INSURANCE ADDRESS** | **INSURANCE PHONE**

POLICY HOLDER'S NAME | **POLICY HOLDERS DATE OF BIRTH** | **POLICY ID NUMBER** | **GROUP NUMBER**

SECONDARY INSURANCE COMPANY | **INSURANCE ADDRESS** | **INSURANCE PHONE**

POLICY HOLDER'S NAME | **POLICY HOLDERS DATE OF BIRTH** | **POLICY ID NUMBER** | **GROUP NUMBER**

PRIMARY CARE PHYSICIAN | **PHONE NUMBER** | **FAX NUMBER**

Who referred you to our office (if someone other than your PCP)?

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HISTORY OF PRESENT ILLNESS: WHAT IS THE REASON FOR THIS VISIT?

Are you experiencing any of these symptoms in past 2 months?	NO	YES	Comments
Blurred or double vision	[ ]	[ ]	
Sinus problems	[ ]	[ ]	
Recent weight change	[ ]	[ ]	
Fatigue	[ ]	[ ]	
Chest pains	[ ]	[ ]	
Sudden heartbeat changes	[ ]	[ ]	
Swelling of feet, ankles, hands	[ ]	[ ]	
Nausea or vomiting	[ ]	[ ]	
Frequent diarrhea	[ ]	[ ]	
Painful bowel movements or constipation	[ ]	[ ]	
Stomach pain	[ ]	[ ]	
Shortness of breath	[ ]	[ ]	
Frequent urination	[ ]	[ ]	
Irregular periods or painful periods	[ ]	[ ]	
Excessive thirst or urination	[ ]	[ ]	
Heat or cold intolerance	[ ]	[ ]	
Joint stiffness or swelling	[ ]	[ ]	
Weakness of muscles / joints	[ ]	[ ]	
Change in hair or nails	[ ]	[ ]	
Light headed or dizzy	[ ]	[ ]	
Numbness or tingling sensations	[ ]	[ ]	

OTHER:

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BIRTH HISTORY

Birth weight and Birth Length ______ Length of pregnancy (# of weeks) ______

Did the mother experience any illnesses during pregnancy?	[ ] No [ ] Yes
Did the mother have diabetes during pregnancy?	[ ] No [ ] Yes
Did the mother smoke during pregnancy?	[ ] No [ ] Yes
Did the mother use alcohol/drug during pregnancy?	[ ] No [ ] Yes
Was the child a vaginal delivery?	[ ] No [ ] Yes

PAST MEDICAL HISTORY / FAMILY HISTORY Please **check** any condition in biological member

CONDITION	Patient	Patient's Mother	Patient's Father	Patient's Grandparent	Other
ADHD	[ ]	[ ]	[ ]	[ ]	[ ]
Allergies (Hay fever)	[ ]	[ ]	[ ]	[ ]	[ ]
Anxiety/Tend to worry	[ ]	[ ]	[ ]	[ ]	[ ]
Asthma	[ ]	[ ]	[ ]	[ ]	[ ]
Cancer	[ ]	[ ]	[ ]	[ ]	[ ]
Diabetes	[ ]	[ ]	[ ]	[ ]	[ ]
Depression	[ ]	[ ]	[ ]	[ ]	[ ]
Heart Problems	[ ]	[ ]	[ ]	[ ]	[ ]
High Blood Pressure	[ ]	[ ]	[ ]	[ ]	[ ]
High Cholesterol	[ ]	[ ]	[ ]	[ ]	[ ]
Kidney Problems	[ ]	[ ]	[ ]	[ ]	[ ]
Liver Problems	[ ]	[ ]	[ ]	[ ]	[ ]
Lupus	[ ]	[ ]	[ ]	[ ]	[ ]
Organ Transplant	[ ]	[ ]	[ ]	[ ]	[ ]
Seizures	[ ]	[ ]	[ ]	[ ]	[ ]
Sleep Apnea	[ ]	[ ]	[ ]	[ ]	[ ]
Substance Abuse	[ ]	[ ]	[ ]	[ ]	[ ]
Thyroid Problems	[ ]	[ ]	[ ]	[ ]	[ ]
Tobacco/ Alcohol	[ ]	[ ]	[ ]	[ ]	[ ]
Psychiatric Problems	[ ]	[ ]	[ ]	[ ]	[ ]

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PLEASE LIST SURGERIES

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DEVELOPMENT

When did your child first	**Before**	**Baseline**	**After**	**Not Sure**
Crawl?	[ ]	[ ] 9 months	[ ]	[ ]
Say first words?	[ ]	[ ] 9-12 months	[ ]	[ ]
Walk?	[ ]	[ ] 12-15 months	[ ]	[ ]

SCHOOL Current Grade *example: 4th grade* (last grade completed if out of session):

Child/Teen's school performance	[ ] Below Average [ ] Average [ ] Above Average
Average number of school days missed/year	[ ] 0-5 days [ ] 5-10 days [ ] 11-20 days [ ] more than 20 days

MEDICATIONS Please list all current prescriptions and over the counter medication / supplement

____

____

____

____

____

MEDICATION ALLERGIES

____

____

____

MENSTRUAL HISTORY **(Pre-Teen or Teen Girls only - all others leave blank)**

Has your child ever had a menstrual period?	[ ] No [ ] Yes If Yes, age at onset years
How long does your child's period usually last?	[ ] Less than 5 days [ ] 5-7 days [ ] more than 7 days
Character of bleeding?	[ ] Light [ ] Moderate [ ] Heavy
Any other problems with menstrual periods?	[ ] No [ ] Yes If Yes, please explain:

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MEDICAL RECORD REQUEST

Requesting from the following facility/ provider:

To: ______________________________ (Name)

______________________________ (Address)

____

______________________________ (Phone)

______________________________ (Fax)

I __________________________________(Patient /GUARDIAN name), hereby request and authorize you to send all of INPATIENT and OUTPATIENT **progress notes, labs, x-rays, or other tests and discharge** summaries that are in my medical records for:

Patient Name_________________________ **Patient Date of Birth**:______________________.

Patient or Guardian Signature:_________________________**Date:** _____________________

Reason patient wants information disclosed (Example: Physician Referral/Consultation)

____

____

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