YUMA REGIONAL MEDICAL CENTER

PEDIATRIC ENDOCRINOLOGY NEW PATIENT INFORMATION SHEET – For Patient with Diabetes

Patient Name _____

DOB _____ **Date of Diagnosis** _____

Allergies: _____

Condition ☐ Type 1 diabetes ☐ Type 2 diabetes ☐ Secondary diabetes ☐ Unknown type

Insulin dependent ☐ Yes ☐ No

Insulin pump ☐ Yes ☐ No If Yes, pump brand _____ Start Date _____

List **all medications** patient takes, including over-the-counter (OTC) medications and vitamins. Include specific doses and when taken. If you don't know, please call your pharmacist to confirm.

_____

_____

If currently taking insulin, check all types that apply

Lantus/Glargine 100µ/mL	□ Vial and syringe	□ Pen
Basaglar/Glargine 100µ/mL	□ Vial and syringe	□ Pen
Tresiba/Degludec 100µ/mL or 200µ/mL	□ Vial and syringe	□ Pen
Levemir/Detemir 100µ/mL	□ Vial and syringe	□ Pen
Humalog/Lispro 100µ/mL	□ Vial and syringe	□ Pen
Novolog/Aspart 100µ/mL	□ Vial and syringe	□ Pen
Humalog 70/30 100µ/mL	□ Vial and syringe	□ Pen
Novolin 70/30 100µ/mL	□ Vial and syringe	□ Pen

Other: _____

Check the type of pen needles you use (if on insulin)

□ BD Ultrafine Mini 31G x 5mm (purple box) □ BD Ultrafine Nano 32G x 4mm (green box)
Other: _____

Check the type of glucometer you use

☐ One Touch Ultra ☐ One Touch Verio ☐ AccuChek Aviva ☐ Freestyle Lite ☐ Bayer Contour

Other: _____

Personal Medical History: (Please check all that apply)

□ Thyroid disorder	□ Diabetes mellitus	□ High cholesterol	□ Fatty liver
□ Irregular periods	□ Growth disorder	□ Bone disease	□ Pituitary insufficiency
□ Adrenal disorder	□ Asthma	□ Arthritis	□ Seizures
□ Cancer	□ Hearing loss	□ Vision loss	□ Celiac disease
□ Inflammatory bowel disease	□ Bladder or kidney disease	□ ADHD	□ Development or intellectual disorder

Other: _____

Surgical History (Please list all prior surgeries and approximate dates performed)

_____

_____

Birth History

Gestational Age (weeks) _____ □ Full Term □ Preterm

Method: □ Vaginal □ Breech □ C-section Birth Weight _____ Birth Length _____

Complications: _____

Medications during pregnancy: _____

Social and Cultural History

Current Living Situation (Check all that apply) ☐ Single Family Household ☐ Multi-generational Household

☐ Other _____ School name _____ Grade _____

504 plan at school ☐ Yes ☐ No School nurse present to help with diabetes management ☐ Yes ☐ No

Extra set of diabetes supplies at school ☐ Yes ☐ No

Family History

Father Age _____ Ht _____ **Mother** Age _____ Ht _____ Age of first menstrual cycle: _____

Siblings _____

Does anyone related to you by blood have the following conditions? (please check all that apply)

	Family Member(s)		**Family Member(s)**
□ Diabetes (type 1 or type 2)	_____	□ Taking hormone injections	_____
□ Low thyroid levels	_____	□ Autoimmune disease	_____
□ High thyroid levels	_____	□ High blood pressure	_____
□ Thyroid cancer	_____	□ High cholesterol	_____
□ Adrenal gland problems	_____	□ Heart disease	_____
□ Fertility problems	_____	□ Stroke	_____
□ Pituitary gland problems	_____	□ Other	_____