USF DIABETES CENTER
UNIVERSITY OF SOUTH FLORIDA

USF HEALTH

PEDIATRIC NEW PATIENT FORM

Please complete pages 1-12 and mail or fax to:

USF Diabetes Center
12901 Bruce B. Downs Blvd, MDC 62
Tampa, FL 33612
Secure Fax: (813) 974-3313
Phone: (813) 396-2580

Today's Date:	Name of Person Completing this form:	Relationship to Patient:

PATIENT INFORMATION

Patient's Last Name: First: Middle:	Nickname:	Date of Birth:	Age:	Sex: ☐ M ☐ F

Language spoken at home:

Race/Ethnicity:

☐ American Indian ☐ Black/African American ☐ Hispanic/Latino/Mexican ☐ White/Caucasian

☐ Native Hawaiian/Pacific Islander ☐ Asian/Chinese/Japanese/Korean ☐ Other

Street address:	Social Security #:	Home Phone #: ( )

P.O. Box:	City:	State:	ZIP Code:

The patient lives with: ☐ Biological Parents ☐ Biological Mother ☐ Biological Father ☐ Guardian

Mother's Name:	Email Address:	Home Phone #:	Cell#:

Mother's Mailing Address Including City, State and Zip (if different than patient):

Father's Name:	Email Address:	Home Phone #:	Cell#:

Father's Mailing Address Including City, State and Zip (if different than patient):

Guardian's Name:	Email Address:	Home Phone #:	Cell#:

Guardian's Mailing Address Including City, State and Zip (if different than patient):	Relationship to Patient:

Referred to the Center by (Please check one box): ☐ Physician ☐ Hospital ☐ Insurance plan ☐ Family ☐ Friend ☐ Self ☐ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone #: ( )	Alternate phone #: ( )

CONSULTATION INFORMATION	
Name of Referring Physician:	Phone #:
Address including City, State and Zip :	
Name of Primary Physician (if different from above):	Phone #:
Address including City, State and Zip :	
Why did you bring your child to the Diabetes Center today? ☐ Newly Diagnosed ☐ Poorly Controlled Diabetes ☐ Testing for possible diabetes ☐ Research study participation ☐ Insulin Pump Therapy ☐ Continuous Glucose Monitoring ☐ Diabetes Education ☐ Counseling Services	
Is this visit a family/patient concern, doctor's concern or both?	
Please list any problems/concerns that you feel need to be discussed at this appointment:	
Will you need transportation assistance to attend future appointments? ☐ Yes ☐ No	

DIABETES HISTORY

Date and location of diagnosis:	Was the patient admitted to the hospital? ☐ Yes ☐ No	Length of stay:

Was the patient diagnosed with diabetic ketoacidosis? ☐ Yes ☐ No ICU stay? ☐ Yes ☐ No If yes, the # of days in ICU:

Have you had previous diabetes education? ☐ Yes ☐ No If yes, where and when?

How often has the patient been seen by a diabetes doctor?

What was the last date and result of a Hemoglobin A1C?

What kind of blood glucose meter do you use to test blood sugars?

How often are blood sugars tested?

What target range do you try to keep the blood sugars between?

How often do you have a low blood sugar?

What do you consider a low blood sugar?

When is a low blood sugar most likely to occur in the patient?

What symptoms occur if the blood sugar is low?

How do you treat a low blood sugar?

Do you have Glucagon? ☐ Yes ☐ No If yes, what is the expiration date?

When do you use Glucagon?

Have any seizures or unconscious episodes occurred? ☐ Yes ☐ No

If yes, include dates and times of the seizures:

How often is the blood sugar over 250?

When is a high blood sugar most likely to occur?

Do you have Ketostix? ☐ Yes ☐ No

Do you test urine/blood for ketones? ☐ Yes ☐ No If yes, what do you do if ketones are present?

Have there been hospitalizations for high blood sugars or diabetic ketoacidosis since diagnosis? ☐ Yes ☐ No

If yes, include dates and comments regarding cause of high blood sugar and need for hospitalizations:

DIABETES MEDICATIONS

Insulin Injections: please fill out this section if you are injecting insulin.

Please list the type(s) of insulin used and amount of units needed to cover food eaten and high blood sugar.
If you are counting carbohydrates, include the carbohydrate to insulin ratio, the correction factor, and the target range of the blood sugar.

	Insulin Type	Correction Factor:_____ Target:_____	Units Required
Breakfast		Carb to insulin Ratio	
Snack		Carb Insulin Ratio	
Lunch		Carb to insulin Ratio	
Snack		Carb Insulin Ratio	
Dinner		Carb to insulin Ratio	
Snacks		Carb to insulin Ratio	
Bedtime		Carb to insulin Ratio	

What do you use to inject insulin? ☐ Syringes ☐ Pen (include what kind)

Who gives the injections? ☐ Child ☐ Mother ☐ Father ☐ other

What injection sites are used? ☐ Arm ☐ Thigh ☐ Hip ☐ Abdomen ☐ Buttocks ☐ other

Does your child take any other medications? ☐ Yes ☐ No If yes, please list:

Please List any concerns you have regarding your child's diabetes medications and insulin injections.

Insulin Pump: Please fill out this section if you are using an insulin pump

When was pump therapy started?	Who prescribed it?
What is the brand and model of the pump?	What type of infusion set is used?
What is the length of the cannula?	Do you ever get infections at the site? ☐ Yes ☐ No If yes, how often?
How often do you change the infusion set? Every days.	Any problem with the infusion set sticking to the skin? ☐ Yes ☐ No

What insertion sites are used? ☐ Arm ☐ Thigh ☐ Hip ☐ Abdomen ☐ Buttocks ☐ other

Do you adjust basal rates? ☐ Yes ☐ No	Do you ever use temporary basal rates? ☐ Yes ☐ No

Do you use alternate basal patterns? ☐ Yes ☐ No If so, for what event?

Do you adjust your bolus settings? ☐ Yes ☐ No	Do you use extended (square or dual wave) food boluses? ☐ Yes ☐ No
Do you have syringes? ☐ Yes ☐ No	Where do you get your pump supplies?

Any problems receiving pump supplies? ☐ Yes ☐ No

Do you have a plan for injections in the event of pump failure? ☐ Yes ☐ No

Do you use injections in addition to what your pump delivers? ☐ Yes ☐ No ☐ Sometimes

Do you have a prescription for long acting insulin? ☐ Yes ☐ No If yes, what type of insulin?

Do you disconnect from the pump more than one hour a day? ☐ Yes ☐ No

If yes, why, how long, how often?

What plan do you use when disconnected to the pump?

At what blood sugar level do you treat low blood glucose?

How do you treat low blood glucose? ☐ Suspend the pump ☐ Eat a quick acting carb ☐ Set a temporary basal rate

☐ Other (describe)

Standard: Basal Profile Please enter the start time of each basal rate and the number of units delivered

Time	Units per hour	Time	Units per hour
Basal Rate #1 12 AM		Basal Rate #5	
Basal Rate #2		Basal Rate #6	
Basal Rate #3		Basal Rate #7	
Basal Rate #4		Basal Rate #8	

What is your child's carb to insulin ratio? Breakfast _____ Lunch _____ Dinner _____ Snacks _____

What is your child's correction factor? AM _____ PM_____

What is your child's blood glucose target? _____

NUTRITION

Do you have dietary restrictions? ☐ Yes ☐ No If yes, what kind:

Have you been given a diabetes meal plan? ☐ Yes ☐ No

If yes, what kind? ☐ Exchange lists for meal planning ☐ Insulin : Carb ratios (If yes, what calculations are you currently using?)
☐ Consistent Carb ranges for meals and snacks ☐ Other (please explain)

If you do not have a meal plan, how do you decide what foods to eat? Check all that apply.

☐ Eat whatever I want
☐ Eat until I'm full
☐ Avoid/limit sugar and sweets
☐ Limit intake of starchy foods
☐ Limit intake of fatty or fried foods
☐ Eat whatever is available
☐ Other (please explain)

Who discussed your meal plan with you initially?	When?
Has your meal plan been changed since then? ☐ Yes ☐ No	If yes, when?

Please describe any changes you would like made in your meal plan:

What factors make it a challenge to follow a meal plan? (check all that apply)

☐ Changes in appetite	☐ Not enough food in meal plan	☐ Frequent low blood sugars
☐ Refusing to eat	☐ Peer or social pressures	☐ Disliking food
☐ School or work schedule	☐ Cost of food	☐ Activity schedule
☐ Bingeing	☐ Food not available	☐ Purging
☐ Too much food in meal plan	☐ Other	

Who usually prepares the meals for the person with diabetes?

☐ The person with diabetes	☐ Family/friend who lives with you	☐ Parent
☐ Other person(s)	☐ Grandparent	☐ Eat out most of time

Are you/your child with diabetes happy with the current weight? ☐ Yes ☐ No

Would you /your child with diabetes like to weigh more? ☐ Yes ☐ No

Would you/your child with diabetes like to weigh less? ☐ Yes ☐ No

Has there been a recent weight gain? ☐ Yes ☐ No

Has there been a recent weight loss? ☐ Yes ☐ No

Does your child with diabetes take vitamins and/or mineral supplements? ☐ Yes ☐ No

If yes, please list :

What does your child drink when he/she is thirsty?

Please complete the meal plan table below. Include the time of meals/snacks and total grams of carbohydrates eaten if known.

	Breakfast	AM snack	Lunch	PM snack	Dinner	Bedtime snack
Time						
Grams of Carbs						

BIRTH HISTORY

What were the ages of the parents at child's birth? Mother: Father:

Please select any problems with the mother's health during pregnancy:

☐ Diabetes ☐ High fever ☐ High blood pressure ☐ Infection/Viral illness ☐ Injury ☐ Swelling of hands/feet

☐ Other

Duration of pregnancy:

☐ Full term ☐ Premature- total number of weeks _____ ☐ Overdue- total number of weeks _____

Delivery: ☐ Vaginal ☐ Caesarean Section (C-section) – include reason:

Please list any other problems with the mother's health around the time of delivery (high blood pressure, seizure, bleeding, etc.)

Please list any medications taken during pregnancy:

During pregnancy, the number of cigarettes smoked: During pregnancy, the number of alcoholic drinks per day:

Child's birth weight: Child's birth length:

Were there any problems at or around the time of delivery?

☐ No problems ☐ Required Oxygen ☐ High/Low Blood Sugar ☐ Jaundice ☐ Feeding difficulties

☐ Other _____

Any birth defects? ☐ No ☐ Yes (please describe) _____

How long did your child stay in the hospital after birth?

GROWTH / DEVELOPMENT

Would you describe your child's development as normal? ☐ Yes ☐ No

Please describe your impression of your child's growth so far (example: gained weight and length the first year, then didn't grow taller but gained weight, etc.)

Was your child breastfed? ☐ No ☐ Yes- include number of months

Was your child ever on formula? ☐ No ☐ Yes- include type and age introduced

What age did your child first drink cow's milk?

At what age did your child:

Sit upright alone? Crawl? Walk alone? Say first words? Talk in sentences?

Become toilet trained? Lose first baby tooth? First permanent tooth? Dress self?

Many conditions, including diabetes, can affect growth. It is extremely valuable for our assessment if we have this information. Please ask your doctor to send us a copy of your child's growth chart and growth records. Our fax number is (813) 974-3313.

PATIENT MEDICAL HISTORY

Medical Condition Please check yes if you have been diagnosed with any of the following medical conditions		Comments:
High or low blood pressure	☐ Yes	
Autoimmune disorders (e.g. Celiac, Lupus, Crohn's Disease, Ulcerative Colitis, Rheumatoid Arthritis, Vitiligo)	☐ Yes	
Heart murmur	☐ Yes	
High cholesterol/Abnormal Lipids	☐ Yes	
Thyroid disease	☐ Yes	
Liver problems	☐ Yes	
Kidney problems	☐ Yes	
Cancer	☐ Yes	
History of Chemotherapy/radiation	☐ Yes	
Anemia (low blood count)	☐ Yes	
History of blood transfusion	☐ Yes	
Meningitis	☐ Yes	
Seizures	☐ Yes	
Head injury	☐ Yes	
Abnormal growth/weight problems	☐ Yes	
Calcium problems	☐ Yes	
Kidney stones	☐ Yes	
Bone problems	☐ Yes	
Early/late puberty	☐ Yes	
Adrenal gland problems (Addison disease)	☐ Yes	
Abnormal sex organs	☐ Yes	
Pituitary gland problems	☐ Yes	
Hearing Problems	☐ Yes	
Learning disabilities	☐ Yes	
Mental Retardation	☐ Yes	
Ear Infections	☐ Yes	
Other	☐ Yes	

Please describe all previous hospitalizations, dates, age, and reason

Hospitalization Date	Age	Reason

Please list all previous surgeries and approximate date and age at surgery

Surgery Date	Age	Reason

Does your child have any allergies? ☐ Yes ☐ No

If yes, please list them:

Are the immunizations up to date? ☐ Yes ☐ No

Has your child received a flu shot? ☐ Yes ☐ No If yes, when was last one given?

REVIEW OF SYSTEMS: Please check" Yes" and describe symptoms/ problems that have occurred with your child

Review of systems:	Yes	Please describe
GENERAL		
Feeling fine	☐	
Normal appetite	☐	
Recent weight change	☐	Weight Loss # lbs _____ Weight Gain # lbs _____
Normal Level of activity	☐	
Headache	☐	
Fever	☐	
Frequent infections	☐	
Birth Defects	☐	
SKIN		
Birthmarks/Rashes/Skin coloring/Acne	☐	
Stretch marks	☐	
Dark appearing skin on neck or in skin folds	☐	
EYES	☐	
Vision Problems	☐	
Needs eyeglasses or wears contacts	☐	
EAR, NOSE, THROAT		
Normal Sense of smell	☐	
Lumps or pains in the neck	☐	
Difficulty swallowing/Change in voice	☐	
CARDIOVASCULAR		
Palpitations/Fast heart beat	☐	
RESPIRATORY		
History of asthma or other lung disease	☐	
Use of steroids to aid breathing	☐	
Difficulties in breathing/wheezing/cough	☐	
GASTROINTESTINAL		
Constipation (hard bowel movements)	☐	
Diarrhea (liquid stools)	☐	
Vomiting	☐	
Stomach pains	☐	
GENITOURINARY		
Kidney/bladder problems	☐	
ENDOCRINE		
Gets very cold or very hot easily	☐	
Early or late sexual development	☐	
Breast discharge	☐	
Adult body odor	☐	
Abnormal facial/body hair	☐	
Vaginal discharge	☐	
Menstrual periods (regularity, length, etc.)	☐	Date of 1st menstrual period_____
Hypoglycemia (low blood sugar)	☐	
Fainting	☐	
Convulsions	☐	
Excessive thirst	☐	
Excessive hunger	☐	
Excessive urination/	☐	
Bedwetting/Urinary accidents	☐	
HEMATOLOGIC/ONCOLOGIC		
Easy bruising or bleeding	☐	
MUSCULOSKELETAL		
Muscle pains or weakness	☐	
Joint pain or swelling	☐	
Swelling of hands or feet	☐	
NEUROLOGIC		
Abnormal head size	☐	
PSYCHIATRIC/DEVELOPMENTAL		
Hyperactivity/Behavior Problems	☐	
Depression	☐	
Nervousness	☐	

PSYCHOSOCIAL HISTORY

I/We have concerns about (check all that apply):

☐ Fear of needles	☐ Family conflicts about diabetes	☐ Telling others about diabetes
☐ My child getting his/her insulin	☐ Stress	☐ My child cariig for themselves
☐ My child going to college with diabetes	☐ Other:	

1. Does your child have a history of behavior problems (for example: not following rules at home or school, arguing with adults, being suspended or expelled from school due to behavior, difficulty paying attention)? ☐ Yes ☐ No

2. Does your child show one or more symptoms of depression (for example: sadness, anger, irritability, not having fun in activities, sleep problems)? ☐ Yes ☐ No

3. Does your child show one or more symptoms of anxiety or nervousness? (for example: difficulty staying away from home, avoiding thing or situations that makes he/she frightened) ☐ Yes ☐ No

4. Are you concerned about how your child is coping with the diagnosis of diabetes? ☐ Yes ☐ No

5. Have you been have trouble coping with your child's diagnosis of diabetes? This may include having symptoms of depression or anxiety that are listed above. ☐ Yes ☐ No

6. Please check any of the following stressful events have happened to the child or family over the last year:

☐ Frequent problems getting along with family	☐ Frequent problems getting along with friends	☐ Move to new school or home
☐ Divorce or separation of parents	☐ Remarriage of parents	☐ Negative change in family's financial circumstances
☐ Death of a family member or close friend	☐ Other major life change or stressful event	

7. Does your child complain of feeling SICK when they fell uncomfortably full? ☐ Yes ☐ No

8. Do you or your child worry they have lost CONTROL over how much they eat? ☐ Yes ☐ No

9. Has your child recently lost more than 14 pounds within three months? ☐ Yes ☐ No

10. Does your child think they are FAT when others say they are too thin? ☐ Yes ☐ No

11. Does FOOD dominate your child's life? ☐ Yes ☐ No

12. Would you like to speak to the Diabetes Center psychologist about your child's mood, behavior or coping? ☐ Yes ☐ No

FAMILY & SOCIAL HISTORY

	Lives at home	Age	Height	Weight	Age of 1st period/sexual development	Education Level	Occupation
Mother	☐ Yes ☐ No						
Father	☐ Yes ☐ No						
Brother/Sister	☐ Yes ☐ No						
Brother/Sister	☐ Yes ☐ No						
Brother/Sister	☐ Yes ☐ No						
Brother/Sister	☐ Yes ☐ No						
Brother/Sister	☐ Yes ☐ No						

Are the child's parents related in any way (example: distant cousins)? ☐ Yes ☐ No

Other caregivers: Please complete the table below for each caregiver or household member not listed above:

Name	Relationship to patient	Age	Education Level	Occupation

Does the patient:

Smoke?: ☐ Yes ☐ No # of packs: Does anyone else in family? ☐ Yes ☐ No

Chew tobacco?: ☐ Yes ☐ No How often: Does anyone else in family? ☐ Yes ☐ No

Use alcohol?: ☐ Yes ☐ No # of drinks per week: Does anyone else in family? ☐ Yes ☐ No

Use drugs? ☐ Yes ☐ No What type and how often: Does anyone else in family? ☐ Yes ☐ No

Is the patient sexually active? ☐ Yes ☐ No If yes, is contraception used? ☐ Yes ☐ No

What special religious observances would you like us to know about?

What are your child's favorite activities?

My child attends: ☐ Public School/Daycare ☐ Private School ☐ Home Schooled

Name of child's school if applicable: Current grade:

What year will your child graduate from high school? Has your child ever repeated a grade?

What are your child's typical grades?

Is there a nurse available at school? ☐ No ☐ Yes: Part-time ☐ Yes: Full-time

Are there other care providers at school? ☐ No ☐ Yes: Part-time ☐ Yes: Full-time

Family Medical History: Please check" yes" if a <u>family member</u> has been diagnosed with any of the following medical conditions. Please state the relationship of the family member to the patient.

Family Medical Condition	YES	Relationship Of Family Member To Patient
Diabetes	☐	
Autoimmune Disorders (e.g. Celiac, Lupus, Crohn's Disease, Ulcerative Colitis, Rheumatoid Arthritis, Vitiligo, Multiple sclerosis)	☐	
High or low blood pressure	☐	
Heart murmur	☐	
High cholesterol/Abnormal lipids	☐	
Heart disease/Stroke	☐	
Death from heart disease	☐	How old was your relative when they died?
Thyroid disease	☐	
Liver problems	☐	
Kidney problems	☐	
Cancer	☐	
History of Chemotherapy/radiation	☐	
Anemia (low blood count)	☐	
History of blood transfusion	☐	
Meningitis	☐	
Seizures	☐	
Head injury	☐	
Abnormal growth/weight problems	☐	
Calcium problems	☐	
Kidney stones	☐	
Bone problems	☐	
Early/late puberty	☐	
Adrenal gland problems (Addison disease)	☐	
Abnormal sex organs	☐	
Pituitary gland problems	☐	
Hearing Problems	☐	
Learning disabilities	☐	
Autism/ (Asperger's Syndrome)	☐	
Mental Retardation	☐	
Ear Infections	☐	
Other	☐	

Information reviewed with family.

Physician/Provider Signature: _____ Date: _____