| UNIVERSITY OF MICHIGAN HOSPITALS & HEALTH CENTERS<br>Pediatrics - Endocrinology<br>**Health History Questionnaire – Pediatric Diabetes** | MRN:<br>NAME:<br>BIRTHDATE:<br>CSN: |
|---|---|

Date of appointment: _____/_____/__________ (mm/dd/yyyy)

Who came with the patient today? ☐Mother ☐Father ☐Both ☐No one ☐Other (specify) ___________________

What concerns do you have today? ____________________________________________________________________

**Review of Systems** *Please check/explain all that apply to your child*

☐Allergies/Asthma ☐Stomach ache/Bloating ☐Seizures ☐Headaches

☐Fatigue ☐Constipation/Diarrhea ☐Site infections ☐Joint pain/Numbness

☐High blood pressure reading ☐Sleep difficulties ☐Blurring of vision ☐Feeling of depression

☐Difficulty breathing ☐Colds

Other conditions/medications besides insulin: ___________________________________________________

________________________________________________________________________________________________

**Has your child had:**

Moderate/large ketones since last visit? ☐No ☐Yes

A hospital admission or Emergency Department visit since last visit? ☐No ☐Yes

How often has your child had low blood sugars (BS) since last visit?

☐Rarely ☐1-2 times per week ☐3-4 times per week ☐Daily

At what number does your child feel low and how do you treat it? _____________________________________

What are your child's symptoms of a low? ____________________________________________________

Have the symptoms changed since the last visit? ☐No ☐Yes

When was your child's last dilated eye exam? Month __________ Year __________

**Social History**

Who lives with the patient? ______________________________________________________________

Changes in home life or family health? ____________________________________________________

Attends school / day care? ☐No ☐Yes Grade: ______________

Number of missed school days due to health issue: __________ days

Number of missed parent work days related to child's diabetes since last visit: __________ days

Have you discussed the following topics with your child?

Smoking and diabetes ☐No ☐Yes

Alcohol and diabetes ☐No ☐Yes

Sexual activity and diabetes ☐No ☐Yes

Does your child check blood sugar before driving? ☐Always ☐Sometimes ☐Never ☐Not applicable

Menstrual periods: ☐No ☐Yes ☐Not applicable If yes, date of last menstrual period ________________

**Exercise**

What is the average number of days per week that your child exercises more than 20 minutes? _________days per week

List type of exercise and explain how you manage your diabetes with activity: _________________________

________________________________________________________________________________________________

Is your child currently on a sports team? ☐No ☐Yes

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|---|---|

**Monitoring** *Please have BS logs ready for review by doctor/diabetes educator*

Which meter used? ______________________________ How often do you check BS? __________ times per day

Do you keep a log book? ☐No ☐Yes Who records/reviews BS and how often? ___________________________

**Insulin Therapy**

How does your child administer insulin? ☐Syringe ☐Pens ☐Pumps ☐I-Port ☐Not applicable

Check insulin injections/set sites? ☐Arms ☐Legs ☐Buttock ☐Abdomen

Does your child? ☐Use an Insulin to Carb ratio and Correction factor ☐Use an Insulin to Carb ratio only

☐Use a set dose with set meal plan

***To be completed if your child is on insulin shots (if your child is on a pump skip to next section)***

What is the total daily dose of Lantus®/Levemir®? _____ units At what time is Lantus®/Levemir® given? ________

What is the average daily dose of rapid acting insulin (Novolog®, Apidra®, Humalog®)? ________ units

| **Average carbs per meal** | **Carb Ratio or Dose** | **Correction Ratio:** | **Target BS:** |
|---|---|---|---|
| __________________ grams | Breakfast ________________________ | Day _______________ | Day ___________ |
| __________________ grams | Snack ___________________________ | | |
| __________________ grams | Lunch ___________________________ | Night _______________ | Night: __________ |
| __________________ grams | Snack ___________________________ | Do you take your insulin before or after you eat? | |
| __________________ grams | Dinner ___________________________ | ☐Before ☐After | |
| __________________ grams | Dinner ___________________________ | | |

***If your child is on insulin pump therapy complete this section***

Which pump do you use? ☐Medtronic© ☐Animas® ☐Tandem® ☐OmniPod®

Which infusion set (specify)?________________________

| **Time** | **Basal Rates** | **Carb Ratio** | **Correction Ratio** | **Target BS** |
|---|---|---|---|---|
| _________AM/PM | _______units/hr | _____AM/PM 1:_____gm | _____AM/PM 1: _______ | >_______mg/dl |
| _________AM/PM | _______units/hr | _____AM/PM 1:_____gm | _____AM/PM 1: _______ | >_______mg/dl |
| _________AM/PM | _______units/hr | _____AM/PM 1:_____gm | _____AM/PM 1: _______ | >_______mg/dl |
| _________AM/PM | _______units/hr | _____AM/PM 1:_____gm | _____AM/PM 1: _______ | >_______mg/dl |
| _________AM/PM | _______units/hr | _____AM/PM 1:_____gm | | |
| _________AM/PM | _______units/hr | _____AM/PM 1:_____gm | | |

Total daily basal units: _________

Total Daily Doses: ________, ________, ________, ________, ________

_________________________________________________ _____/_____/__________ (mm/dd/yyyy)

Printed name of person who completed this form Date