BMG | THE ENDOCRINE CLINIC

# EARLY SEXUAL DEVELOPMENT QUESTIONNAIRE

(IF YOU CANNOT ANSWER A QUESTION, PLEASE LEAVE IT BLANK. PLEASE PRINT)

NAME: _____ DATE: _____

DATE OF BIRTH: _____ / _____ / _____ CURRENT AGE: _____ YEARS _____ MONTHS
MONTH DAY YEAR

A. Approximate Age Of:

| | | | |
|---|---|---|---|
| 1. | Breast Development | _____ | ☐ None |
| 2. | Pubic Hair | _____ | ☐ None |
| 3. | "Arm Pit" Hair | _____ | ☐ None |
| 4. | Acne | _____ | ☐ None |
| 5. | Body Odor | _____ | ☐ None |
| 6. | Greasy Skin | _____ | ☐ None |
| 7. | Behavioral Changes | _____ | ☐ None |
| 8. | Menses | _____ | ☐ None |

B. Has There Been a History Of:

| | | | |
|---|---|---|---|
| 1. | Head Trauma | ☐ Yes | ☐ No |
| 2. | Loss of Consciousness | ☐ Yes | ☐ No |
| 3. | Seizure | ☐ Yes | ☐ No |
| 4. | Motor Vehicle Accident | ☐ Yes | ☐ No |
| 5. | Surgery of the Head or Face | ☐ Yes | ☐ No |
| 6. | Meningitis | ☐ Yes | ☐ No |
| 7. | Radiation to the Head/Spine | ☐ Yes | ☐ No |

If Yes, Please Describe: _____

_____

C. Does Your Child Have Any of the Following:

| | | | |
|---|---|---|---|
| 1. | Severe or Chronic Headaches | ☐ Yes | ☐ No |
| 2. | Frequent Urination & Drinking Behavior | ☐ Yes | ☐ No |
| 3. | Unexplained Vomiting | ☐ Yes | ☐ No |
| 4. | Recent Growth Spurt | ☐ Yes | ☐ No |
| 5. | Areas on Skin of Increased/Decreased Pigment Markings | ☐ Yes | ☐ No |

If Yes, Please Describe: _____

_____

D. Current Medications:

_____

E. Family History: (if Yes, Please List Relationship)

| | | Relationship |
|---|---|---|
| 1. | Diabetes | _____ |
| 2. | Thyroid Problem | _____ |
| 3. | Early Puberty | _____ |
| 4. | Neurofibromatosis | _____ |

| Family Member | Age | Approx. Height | Age of Puberty |
|---|---|---|---|
| Father | _____ | _____ | _____ |
| Mother | _____ | _____ | _____ |
| Sibling | _____ | _____ | _____ |
| Sibling | _____ | _____ | _____ |
| Sibling | _____ | _____ | _____ |