PEDIATRIC GASTROENTEROLOGY NEW PATIENT FORM

Patient Name:_______________________________________ Date of Birth:_________________

Referring Physician & Practice:____

Primary Care Physician & Practice:____

Primary Reason for Visit:____

History of present illness: Please list to the best of your ability when the problem started, where it is located, relationship to meals or activities, associated symptoms, severity, timing	
Past Medical history: Please list any prior surgeries, major illnesses and hospitalizations. List any prior Xrays, ultrasounds, CT scan, endoscopy, diagnostic labs, stool studies	

Please circle your child's current GI – related symptoms: (circle all that apply):

Infrequent stools	Growth delay	Abdominal pain
Hard stools	Weight loss	Vomiting
Too frequent stools	Poor weight gain	Flatulence (gas)
Too loose stools	Poor feeding	Burping/hiccoughs
Blood in the stool (or on toilet paper)	Regurgitation/spit up	Bad breath (halitosis)
Stool accidents	Heartburn	Abdominal distention/bloating
Rectal pain/rectal itching	Nausea	Irritability
Loss of appetite	Chest discomfort	Excessive crying
	Swallowing difficulty	

Current Medications:

Medication	Dose/frequency	Date started	For what condition

Updated 5/2018

Medication Allergies:____

Food Allergies: Current____Past _________________________________

Special Diet (vegetarian/vegan,etc)_____________________________

Past Medical History

A. Perinatal History

Pregnancy complications? No Yes Describe ____
 # weeks' gestation: ____________
Type of delivery: vaginal c –sxn Breast fed: No Yes How long ___________
Birth weight : ______________________________ Twin delivery? No Yes
Any problems in the nursery: ____
Any jaundice requiring phototherapy : No Yes
Passed meconium in hospital without difficulty: No Yes

Was child adopted? No Yes If yes, were there any known health problems in biologic parent including drug or alcohol use?____
How old was the child at adoption?____

B. Infancy
Did any of the following occur during infancy/early childhood?
Poor feeding - vomiting - colic - reflux - constipation - formula allergy - toilet training trouble

Please elaborate ____
____
____

C. Are there any diagnosed medical conditions ***besides*** what you came here for today
____

EDUCATION/SOCIAL HISTORY

Current Grade ______ Special Education ? _________________________________

Any learning disabilities____

List major extracurricular activities____

How much school has been missed due to the child's current complaint?___________________________________

Substance use (amt/week): alcohol _____ tobacco _____ marijuana_______ other _______________________

Is child currently seeing a therapist?____

Does child have a known psychiatric or developmental diagnosis?____

Other concerns (Eating disorders, relationship concerns)____

Any pets ________________________ Foreign Travel ? where ________________ when________

FAMILY HISTORY (for same sex parents kindly write in the appropriate relationship)

Father's age __________ occupation _____________ health problems__________________________________

Mother's age _________ occupation ____________ health problems__________________________________

Please list siblings (age/gender) and any important health issues they may have:

____

____

Please circle if there was a sperm donor or egg donor

Parents' status: Married Separated Divorced Remarried Widowed cohabitating

Do any family members have the following conditions?

Please circle all that apply and indicate who are the affected members/relatives

Crohn's disease___________________________
Ulcerative Colitis__________________________
Celiac disease____________________________
Lactose intolerance______________________
Barrett's Esophagus______________________
Polyp syndrome__________________________
Colon Cancer under age 50 ________________
Irritable bowel syndrome (IBS)_____________
Food Allergies___________________________
Eosinophilic Esophagitis___________________
Gallstones________________________________
Liver disease/hepatitis_____________________
Ulcers of stomach or duodenum____________
H pylori_______________________________
Cystic fibrosis_____________________________
Autoimmune thyroid disease, lupus, rheumatoid arthritis ________________________
Growth delay____
Alopecia____

REVIEW OF SYSTEMS

Please circle all that apply

1.General

Fever
Weight loss
Weight gain
Difficulty sleeping
Fatigue
Loss of appetite

2. **Eyes**

Change in vision
Blurry vision
Eye discharge

3. **Ear, Nose Throat**

Sinusitis
Hoarseness
Mouth Sores
Frequent cavities
Enamel loss
Sleep apnea

4. **Respiratory**

Chronic cough
Wheezing
Croup

5. **Cardiovascular**

Palpitations
Shortness of breath at rest
Shortness of breath on exertion
Chest pain (not heartburn)
Fainting

6. Skin

Rash
Bruising
Itching
Hair loss

7. Genitourinary

Urinary incontinency (accidents)
Bedwetting
Burning with urination
Urgency to urinate

8. Musculoskeletal

Arthritis
Joint pain
Bone pain
Muscle pain
Back pain

9. Endocrine
Diabetes
Thyroid problems
Menstruation problems

10. Hematologic

Anemia/low iron
Bleeding problems
Bruising

11. Neurologic

Headaches
Dizziness
Fainting
Learning difficulties

12. Psychiatric

Depression/bipolar
Anxiety/mood change
Eating disorder
Obsessive compulsive
Psych hospitalization
Suicide attempt

13. Allergy/immunology

Food allergy
Seasonal Allergy

Is there anything else you think we should know?______________________
____
____
____
____
____
____
____
____
____
____
____
____