Pediatric Gastroenterology Health Form

Date		
Last Name	First Name	Age
Street Address	City	State Zip
Date of Birth	Sex	Home Phone
Mother/Guardian	Occupation	Work Phone
Father/Guardian	Occupation	Work Phone
Pediatrician/Primary Care Doctor		PCP Phone
Other doctors involved with your child's care (Please circle which physician referred you):		
Why are you here to see the doctor?		

A. Past Medical History

1. Birth History: Birth Weight:_____ Length:_____ Full Term/Premature (circle one)

Pregnancy problems: _____

Labor/Delivery: Vaginal/C-Section (circle one) Describe any problems:_____

Problems in the Nursery/1st month of life:_____

2. List any medical problems that your child has.

List all medications (include over the counter and herbal)

3. List any hospitalizations that your child has had. Include his/her age, where hospitalized, and the reason for the hospitalization.

Drug Allergies:

Are immunization up to date?

_____ Yes _____ No

4. List any surgeries/procedures, with the dates performed, that your child has had. Include those done as an outpatient.

B. Family History

1. Has anyone, in the patient's family (or relative) has any of the following? If yes, check the box and list the persons relationship to the patient, next to the problem.

- □ Anemia
- □ Asthma, Emphysema
- □ Cancer (list type)
- □ Celiac disease
- □ Colitis, Crohn's disease
- □ Constipation
- □ Cystic Fibrosis
- □ Diabetes
- □ Gallstones/gall bladder problems
- □ Gastritis/ulcer
- □ Heart disease or stroke
- □ High blood pressure
- □ High cholesterol
- □ Irritable bowel syndrome
- □ Liver problems
- □ Mental retardation/developmental delays
- □ Migraine headaches
- □ Polyps
- □ Seizures
- □ Sickle cell disease or trait

2. Is there any other disease/illness that runs in the family?_____

C. Social History

1. Who lives in the same household with patient?

Name	Age	Relationship to patient	Any health problems

2. Are the parent (s):
□ Single □ Married □ Divorced
□ Separated □ Remarried

3. School History

A.) Grade in school:_____

B.) Performace/grades:_____

C.) Change in behavior/performance?

_____

4. Any unusual stresses at home/school?
□ Yes □ No If yes, explain.

_____

_____

D. Review of Systems: Please check any of the following that are <u>current</u> problems *<u>for your child:</u>*

<u>General</u>
□ Recurrent fevers/temperatures
□ Weight loss
□ Weight gain

<u>Gastrointestinal (Stomach/Intestines)</u>
□ Constipation
□ Soiling underpants
□ Diarrhea
□ Vomiting/spitting up
□ Heartburn
□ Blood in stool
□ Difficulty swallowing
□ Stomach pain
□ Nausea
□ Reflux
□ Liver problems/jaundice/hepatitis

<u>Heart/Blood vessels</u>
□ Heart murmur
□ Heart problems
□ Chest pain
□ Paliptations
□ Irregular heart beat
□ Blood pressure problems

<u>Breathing/Lungs/Chest</u>
□ Coughing
□ Wheezing
□ Asthma
□ Shortness of breath
□ Apnea (stops breathing)
□ Pneumonia
□ Aspiration
□ Tracheostomy

<u>Endocrine (Glands)</u>
□ Thyroid problems
□ Poor growth
□ Other hormone/gland problems

<u>Hematologic (Blood problems)</u>
□ Bleeding disorders/easy bleeding
□ Anemia
□ Received blood
□ Easy bruising
□ Swollen lymph nodes
□ Lumps/growths

<u>Genital/Urinary System</u>
□ Pain/burning with urination
□ Blood in urine
□ Increased frequency/amount of urine
□ Swelling/retaining water
□ Other uniary tract/kidney problems
□ Menstrual problems
□ Age at first menstrual period _____
□ Date last menstrual period ended _____

<u>Musculoskeletal</u>
□ Joint problems
□ Weakness
□ Scoliosis (curved spine)

<u>Skin</u>
□ Skin rashes
□ Acne
□ Easy bruising
□ Birthmark

<u>Neurologic (Brain/Nerves)</u>
□ Developmental delay
□ Headaches
□ Seizures
□ Dizziness
□ Fainting
□ ADHD (hyperactivity)
□ Decreased sensation
□ Decreased muscle strength
□ Other neurologic problems
□ Migraines

<u>Psychology</u>
□ Depression
□ Anxiety
□ Memory loss
□ Sleeping difficulties
□ Hallucinations
□ Paranoia
□ Phobia
□ Confusion

<u>Eyes</u>
□ Wear glasses
□ Blurry vision
□ Double vision
□ Eye pain
□ Blind

<u>Ears/Nose/Throat</u>
□ Ear pain
□ Ear infections
□ Discharge from ears
□ Nose bleeds
□ Sinus problems
□ Mouth ulcers
□ Trouble swallowing
□ Hoarseness
□ Sour taste in mouth
□ Sore throat
□ Dental problems

<u>Allergy/Immune System</u>
□ Allergies
□ Immune problems
□ Frequent infections
□ Unusual infections