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**GASTROENTEROLOGY NEW PATIENT QUESTIONNAIRE**

Please COMPLETE and bring with your or return by email prior to your visit. Please answer all questions to the best of your ability.

| OFFICE USE ONLY |
|---|
| Ht. _____cm |
| Wt. _____kg |
| BP ___/___ |
| Pulse ____ |

## YOUR CHILD'S INFORMATION:

Child's Name:_____ Date of Birth:_____ Age:_____years ____months
Form completed by:_____ Relationship to child:_____

## YOUR CHILD'S SYMPTOMS/YOUR CONCERNS:

**(check all that apply)**

◯Abdominal pain ◯Abnormal liver tests ◯Bloating/Gas ◯Blood in stool ◯ Celiac Disease ◯ Constipation ◯ Crohn's disease ◯ Diarrhea
◯Hepatitis ◯ Jaundice ◯ Obesity ◯ Rectal pain ◯Reflux ◯Slow weight gain ◯ Soiling/stooling accidents ◯ Swallowing pain/dysfunction
◯Ulcerative colitis ◯ Vomiting ◯ Weight loss ◯ OTHER:_____

## REVIEW OF CHILD'S CURRENT SYMPTOMS:

(Check all **CURRENT** medical problems for your child)

GENERAL/CONSTITUTIONAL:
◯ Recurring fevers
◯ Chronic fatigue
◯ Failure to thrive
◯ Slow growth
◯ Developmental delay

EYE/VISION:
◯ Wears glasses
◯ Eye surgery
◯ Lazy eye
◯ Eye injury
◯ Other:_____

EARS/NOSE/THROAT:
◯ Hearing loss
◯ Recurring ear infections
◯ Recurring sinus infections
◯ Recurring strep throat
◯ Ringing in ears

RESPIRATORY:
◯ Pneumonia
◯ Asthma
◯ Reactive airways
◯ Croup
◯ Persistent cough
◯ Shortness of breath
◯ Other:_____

CARDIOVASCULAR:
◯ Murmur
◯ Heart problems
explain:_____
_____

GASTROINTESTINAL:
◯ Bowel Movements:
How Often?_____
Formed or Semi-Formed
◯ Diarrhea
How Often?_____
◯ Constipation
How Often?_____
◯ Blood in Stool
Bright or Dark Red
◯ Bloated feeling
◯ Vomiting How often?_____
Blood or No Blood
◯ GERD
◯ Reflux/Heartburn
◯ Belching or passing gas
Wet or Dry
◯ Feeding problems
◯ Soiling
Other:_____
◯ Stomach pain
_AM _PM _Night _After meals
Location:_____
Constant
Comes/goes ___ <5min ___1-2hrs
Sharp ___Dull ___Burning
Radiates into ___Chest or ___Back
Improves w/ bowel movement

KIDNEY/URINARY:
◯ Urinary tract infections
◯ Bed wetting
◯ Kidney diseases
◯ Kidney reflux
◯ Ovary or testicle diseases

MUSCLES/JOINTS:
◯ Pain/ache in joints
◯ Arthritis
◯ Stiffness/limited on movement
◯ Pain/ache in muscles

NEUROLOGIC:
◯ Headaches
◯ Cerebral palsy
◯ Hydrocephalus
◯ Migraine
◯ Seizures
◯ Faintness/Dizziness
◯ Insomnia

PSYCHOSOCIAL:
◯ Depression
◯ Anxiety
◯ Bipolar
◯ Anorexia
◯ Mood swings
◯ Aggression
◯ Bulimia
◯ ADHD
◯ Behavior disorder
◯ Other:_____
_____

ENDOCRINE:
◯ Diabetes
◯ Thyroid disease
◯ Growth problems
◯ Kidney reflux
◯ Ovary or testicle diseases

WEIGHT:
◯ Binge eating/drinking
◯ Craving certain foods
◯ Excessive weight
◯ Compulsive eating
◯ Water retention
◯ Underweight

ALLERGY/IMMUNE:
◯ Hay fever
◯ Immune deficiency
◯ HIV/AIDS
◯ Other:_____

BLOOD/CIRCULATION:
◯ Anemia
◯ Bleeding tendencies
◯ Sickle cell trait
◯ Sickle cell disease
◯ Thalassemia
◯ Other:_____
_____

SKIN:
◯ Acne
◯ Hives
◯ Rashes/dry skin
◯ Hair loss
◯ Flushing/hot flashes
◯ Excessive sweating

Please continue to next page

## YOUR CHILD'S MEDICAL TESTS:

What tests has your child completed prior to this visit?

- ⬭ Lab (Bloodwork) Where and when was this test performed?_____
- ⬭ X-Rays Where and when was this test performed?_____
- ⬭ CT Scan Where and when was this test performed?_____
- ⬭ Ultrasound Where and when was this test performed?_____

## YOUR CHILD'S MEDICATIONS:

Please list all current medications your child is taking, including over-the-counter medications, vitamins, minerals, or supplements. If medications were recently started, please state when.

| Medication Name | Dose | Frequency | When Started |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Major medical illnesses:_____

Major surgeries (date & type of):_____ _____

_____ _____

_____ _____

_____ _____

## FEMALE PATIENTS:

⬭ Menstrual periods; Date started:_____ Start date of last period:_____

## YOUR CHILD'S PHARMACY:

Pharmacy name:_____Pharmacy phone number:_____

## CHILD'S HOME ENVIRONMENT AND DIET:

Does your child drink: ⬭ City water w/fluoride ⬭ City water w/o fluoride ⬭ Well water ⬭ Bottled water ⬭ Milk ⬭ Juices ⬭ Soda ⬭ Tea/Coffee ⬭ Other:_____

Is there a smoker in the house? ⬭ Yes ⬭ No Do they smoke: ⬭ Inside ⬭ Outside

Any pets in the house? ⬭ Yes ⬭ No If yes, ⬭ Dog ⬭ Cat ⬭ Other:_____

Has your child traveled out of the U.S.A.? ⬭ Yes ⬭ No If yes, when and where:_____

Does your child have dietary restrictions? ⬭ Lactose Free ⬭ Gluten Free ⬭ Low Fructose ⬭ Low Glycemic ⬭ High Fiber ⬭ Cow's Milk Protein Free ⬭ Other:_____

Does your child have any allergies to medications or foods?

Medications(list with reaction) :_____

_____

Foods:(list)_____

_____

_____

Please continue to next page

## YOUR CHILD'S MEDICAL HISTORY AND PAST SURGERIES:

(Check all **PAST** medical problems for your child)

GENERAL/CONSTITUTIONAL:
- ⬭ Recurring fevers
- ⬭ Chronic fatigue
- ⬭ Failure to thrive
- ⬭ Slow growth
- ⬭ Developmental delay

EYE/VISION:
- ⬭ Wears glasses
- ⬭ Eye surgery
- ⬭ Lazy eye
- ⬭ Eye injury
- ⬭ Other:_____

EARS/NOSE/THROAT:
- ⬭ Hearing loss
- ⬭ Recurring ear infections
- ⬭ Recurring sinus infections
- ⬭ Recurring strep throat
- ⬭ Ringing in ears

RESPIRATORY:
- ⬭ Pneumonia
- ⬭ Asthma
- ⬭ Reactive airways
- ⬭ Croup
- ⬭ Persistent cough
- ⬭ Shortness of breath
- ⬭ Other:_____

CARDIOVASCULAR:
- ⬭ Murmur
- ⬭ Heart problems

explain:_____
_____

GASTROINTESTINAL:
- ⬭ Constipation
- ⬭ Bloated feeling
- ⬭ Diarrhea
- ⬭ Vomiting
- ⬭ GERD
- ⬭ Stomach pain
- ⬭ Reflux/Heartburn
- ⬭ Belching or passing gas
- ⬭ Feeding problems
- ⬭ Soiling
- ⬭ Other:_____
_____

KIDNEY/URINARY:
- ⬭ Urinary tract infections
- ⬭ Bed wetting
- ⬭ Kidney diseases
- ⬭ Kidney reflux
- ⬭ Ovary or testicle diseases

MUSCLES/JOINTS:
- ⬭ Pain/ache in joints
- ⬭ Arthritis
- ⬭ Stiffness/limited on movement
- ⬭ Pain/ache in muscles

NEUROLOGIC:
- ⬭ Headaches
- ⬭ Cerebral palsy
- ⬭ Hydrocephalus
- ⬭ Migraine
- ⬭ Seizures
- ⬭ Faintness/Dizziness
- ⬭ Insomnia

PSYCHOSOCIAL:
- ⬭ Depression
- ⬭ Anxiety
- ⬭ Bipolar
- ⬭ Anorexia
- ⬭ Mood swings
- ⬭ Aggression
- ⬭ Bulimia
- ⬭ ADHD
- ⬭ Behavior disorder
- ⬭ Other:_____
_____

ENDOCRINE:
- ⬭ Diabetes
- ⬭ Thyroid disease
- ⬭ Growth problems
- ⬭ Kidney reflux
- ⬭ Ovary or testicle diseases

WEIGHT:
- ⬭ Binge eating/drinking
- ⬭ Craving certain foods
- ⬭ Excessive weight
- ⬭ Compulsive eating
- ⬭ Water retention
- ⬭ Underweight

ALLERGY/IMMUNE:
- ⬭ Hay fever
- ⬭ Immune deficiency
- ⬭ HIV/AIDS
- ⬭ Other:_____

BLOOD/CIRCULATION:
- ⬭ Anemia
- ⬭ Bleeding tendencies
- ⬭ Sickle cell trait
- ⬭ Sickle cell disease
- ⬭ Thalassemia
- ⬭ Other:_____
_____

SKIN:
- ⬭ Acne
- ⬭ Hives
- ⬭ Rashes/dry skin
- ⬭ Hair loss
- ⬭ Flushing/hot flashes
- ⬭ Excessive sweating

OTHER: Any additional information about your child

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

## CHILDS SOCIAL HISTORY:

Is your child adopted?_____Parents are: Married Separated Divorced Not Married
Who lives with your child? Mother Father Siblings Foster parent Grandparents Legal guardian
Age and gender of siblings: Brother(s):____ ages:_____ Sister(s): _____ ages:_____
School/Daycare child attends:_____Grade:_____ Days per week:_____

Drinks alcohol: NO YES Smokes: NO YES Street Drugs: NO YES Sexually active: NO YES

Please continue to next page

## YOUR CHILD'S FAMILY MEDICAL HISTORY:

Other than your child, has anyone in the family had any of the following conditions?
(Please indicate nest to each applicable condition using the following codes): **M**=Mother/**F**=Father/**B**=Brother/**S**=Sister/**MGM**=Maternal Grandmother **MGF**=Maternal Grandfather/**PGM**=Paternal Grandmother/**PGF**=Paternal Grandfather/**MA**=Maternal Aunt/**MU**=Maternal Uncle/**PA**=Paternal Aunt **PU**=Paternal Uncle/**O**=Other(please indicate who)_____

| | | | |
|---|---|---|---|
| ◯ Celiac disease | ◯ Colon cancer | ◯ Constipation | ◯ Crohn's disease |
| ◯ Cystic fibrosis | ◯ Gastroesophageal (acid) reflux | ◯ Gastrointestinal disease | ◯ Irritable bowel disease |
| ◯ Liver disease | ◯ Gallbladder disease | ◯ Polyps | ◯ Ulcerative colitis |
| ◯ Blood disorders | ◯ Allergic diseases (specify)_____ | ◯ Anesthesia problems | ◯ Bleeding problems |
| ◯ High blood pressure (hypertension) | ◯ Diabetes (type) | ◯ Headaches | ◯ Heart disease |
| ◯ Lung Problems | ◯ Infant child death | ◯ Kidney disease | ◯ High cholesterol |
| ◯ Ulcers | ◯ SIDS | ◯ Thyroid disease | ◯ Other:_____ |

## CHILDREN UNDER 2 NEED TO FILL THIS SECTION OUT:

Prior pregnancy?: ◯ No ◯ Yes ◯ Full term____ ◯ Premies_____ ◯ Miscarriages/abortions____ ◯ Living_____
Problems with this pregnancy?: ◯ No ◯ Yes (explain):_____
Problems with this delivery?: ◯ No ◯ Yes (explain):_____
Home after delivery _____days Birth Weight:_____

Breast Feeding?: ◯ No ◯ Yes – Any changes to mother's diet?_____
Initial formula_____ Problems?_____
Changed formula to:_____ Problems?_____
Changed formula to:_____ Problems?_____
Started cereal at _____mos. Started fruits and vegetables at _____mos.

Bowel Movements
Consistency: ◯ Diarrhea ◯ Soft ◯ Hard Frequency: ◯ 1-4x's/day ◯ 1x every 3/days ◯ more than 4x/day ◯ 1x/week
Any blood in stool? ◯ No ◯ Yes – ◯ Bright red ◯ Dark Red Hemoccult done? ◯ No ◯ Yes ◯ Negative ◯ Positive

Spitting up? ◯ After feedings ◯ Any time ◯ w/irritability #times you have to change babies outfit:____ #times mom changes outfit:____
Vomiting? ◯ No ◯ Yes How often?_____ w/blood ◯ No ◯ Yes

Irritability? ◯ No ◯ Yes ◯ All day ◯ Evening only ◯ Day and night
Additional medical problems not listed:_____
Antibiotic therapy: ◯ No ◯ Yes - _____

ANYTHING ELSE ABOUT YOUR CHILD?:

_____
_____
_____
_____
_____