Pediatric Gastroenterology
New Patient Form (over 12 years)
TO BE FILLED OUT BY THE PATIENT

Name ________________________________
Birth date ____________________    Sex _____

I. BIRTH
   1. Any problems as a newborn? ........................................... □ no □ yes
      If yes, what?________________________________________________________

II. NUTRITION
   1. Do any foods bother you?......................... ...................................... □ no □ yes
      If yes, what?________________________________________________________
   2. Are you on a special diet?.......................... ...................................... □ no □ yes
      If yes, what type?____________________________________________________

III. IMMUNIZATIONS
   1. Are you caught up on immunizations?................................. □ no □ yes
      If not, which ones are missing?________________________________________

IV. SCHOOL
   1. What grade are you in? ____________
   2. Are there any problems at school?................................. □ no □ yes
      If yes, what?________________________________________________________
   3. What do you plan to do when you graduate?

________________________________________________________________________

V. PAST MEDICAL HISTORY
   1. Have you ever had surgery?................................. □ no □ yes
      If yes, what kind?____________________________________________________

________________________________________________________________________
   2. Do you have any chronic illnesses?................................. □ no □ yes
      If yes, which ones?___________________________________________________
   3. Have you had to stay in the hospital?................................. □ no □ yes
      If yes, why?__________________________________________________________

________________________________________________________________________

Implemented 3/1/00       Page 1 of 4       Cost Center 4038
4. Have you had any serious accidents? □ no □ yes
   If yes, what?

5. Do you take any medicines? □ no □ yes
   If yes, please list them, and the dose:

6. Do you have any allergies? □ no □ yes
   If yes, what?

VI. FAMILY HISTORY
1. Does anyone in the family have bowel, colon, stomach liver, gall bladder, esophagus, or pancreas problems? □ no □ yes
   If yes, who and what?

2. Anyone in the family with nervous system problems or migraines? □ no □ yes
   If yes, who and what?

3. Are there any allergies in the family? □ no □ yes
   If yes, who and what?

4. Does anyone in the family have other serious health problems? □ no □ yes
   If yes, who and what?

VII. SOCIAL HISTORY
1. Mother: name ____________________ occupation ____________________
2. Father: name ____________________ occupation ____________________
3. Step-parents: name ____________________ occupation ____________________
4. Your Brothers and Sisters:
   Name   Age   Name   Age
   ____________________   ____       ____________________   ____
   ____________________   ____       ____________________   ____
   ____________________   ____       ____________________   ____
5. How many people live in the home?
   Adults ______  Children ______
6. With whom do you live? (Check box)
   □ both parents  □ mother  □ father  □ guardian  □ other

7. Have you traveled out of the US in the past year? ............. □ no □ yes
   If yes, where?____________________________________________________________

8. Are you around animals or pets?.............................................. □ no □ yes
   If yes, which?____________________________________________________________

9. Do you drink well water?............................................................... □ no □ yes

10. Have you been exposed to toxins?............................................. □ no □ yes
    If yes, what?_____________________________________________________________

11. What hobbies, activities, sports, or groups do you participate in?
    _______________________________________________________________________

12. Do you have a job?................................................................. □ no □ yes
    If yes, what?_____________________________________________________________

13. Are you sexually active?........................................................... □ no □ yes
    If yes, do you use birth control?...................................................... □ no □ yes
        If yes, what type?______________________________________________________

14. Do you smoke or use other tobacco products?.......................... □ no □ yes

15. Do you drink alcoholic beverages?............................................. □ no □ yes

**SYSTEMS REVIEW** Please check all that apply.

**General:**  □ poor appetite  □ excessive appetite  □ excessive thirst  □ overweight
   □ underweight  □ weight loss  □ too tall  □ too short
   □ difficulty sleeping  □ excessive sleeping  □ no energy  □ fevers  □ chills

**Skin:**  □ rash  □ lump  □ easy bruising or bleeding  □ itching  □ jaundice

**Eyes:**  □ eye pain  □ blurred vision  □ wears glasses  □ recent change in vision
Ear-Nose-Throat:  □ earaches □ decreased hearing □ frequent nosebleeds
□ bad teeth □ trouble swallowing □ sore throat □ canker sores
□ chronic runny nose
Respiratory:  □ hoarseness □ cough □ wheezing □ difficulty breathing
□ shortness of breath attacks
Cardiovascular: □ chest pain □ heart murmur □ high blood pressure
□ heart trouble
Gastrointestinal: □ abdominal pain □ nausea □ vomiting □ indigestion
□ heartburn □ bloating □ diarrhea □ constipation □ blood in stools
□ stools in underwear (soils)
Urinary: □ painful urination □ increased frequency of urination
□ daytime wetting □ bedwetting
Skeletal: □ back pain □ limp □ swollen joints □ swollen arms or legs
□ joint pain
Neuromuscular: □ headache □ migraine □ weakness □ paralysis
□ numbness □ loss of balance □ dizziness □ fainting
□ unexplained movements or jerks □ convulsions □ staring spells
Behavioral: □ recent changes in the family □ increase in stress
□ are you a worrier □ perfectionist □ depressed □ hyperactive
□ breath-holding spells □ confusion
If you have started your menstrual periods, complete the following:

When did they begin?  Month _________  Year________
Check any that apply: □ painful periods □ excessive bleeding
□ other menstrual problems

Information Recorded by: _______________________________________
Relationship to Patient: _______________________________________