Pediatric Gastroenterology
New Patient Form (6 years - 12 years)
To be filled out by the Parent or Guardian

Name ______________________________________
Birth date _____________________    Sex _____

I. PREGNANCY AND BIRTH
   Please check the box that applies
   1. Any problems during the pregnancy, delivery or after delivery?... □ no □ yes
      If yes, what? ____________________________________________________________
   2. Any problems as a baby?... □ no □ yes
      If yes, what? ____________________________________________________________

II. NUTRITION
   1. Do any foods bother your child?... □ no □ yes
      If yes, what? ____________________________________________________________
   2. Is your child on a special diet?... □ no □ yes
      If yes, what type? ________________________________________________________

III. IMMUNIZATIONS
   1. Is your child caught up on immunizations?... □ no □ yes
      If no, which ones are behind? _____________________________________________

IV. PAST MEDICAL HISTORY
   1. Has your child ever had surgery?... □ no □ yes
      If yes, what kind? _______________________________________________________
   2. Does your child have any chronic illnesses?... □ no □ yes
      If yes, which ones? ______________________________________________________
   3. Has your child had to stay in the hospital?... □ no □ yes
      If yes, why? _____________________________________________________________

Implemented 3/1/00       Cost Center 4038
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If yes, what?

5. Does your child have any allergies? □ no □ yes
   If yes, please list them: ______________________________________________________

6. Does your child take any medications? □ no □ yes
   If yes, please list them and the dose: _________________________________________

V. DEVELOPMENT
1. Does your child have developmental problems? □ no □ yes
   If yes, what?

2. What grade is your child in?

3. Are there any problems with school? □ 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 Child’s Brothers and Sisters:

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5. How many people live in the child’s home? Adults _____ Children ______

6. With whom does the child live? (Check box)

- □ both parents
- □ mother
- □ father
- □ guardian
- □ other

7. Does the child spend regular time with (Check box)

- □ Sitter
- □ Daycare
- □ Other relative

8. Has the child traveled out US in the past year? ....... □ no □ yes
   If yes, where? ____________________________________________

9. Is your child around animals or pets?............................... □ no □ yes
   If yes, which? ____________________________________________

10. Does your child drink well water?................................. □ no □ yes

11. Has your child been exposed to toxins?.......................... □ no □ yes
    If yes, what? ____________________________________________

12. What hobbies, activities, sports, or groups does your child participate in?
    __________________________________________________________________________
    __________________________________________________________________________

SYSTEMS REVIEW Please check all that apply to the child.

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

Cardiovascular: □ chest pain □ 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 □ unexplained movements or jerks
□ convulsions □ staring spells □ fainting

Behavioral: □ recent changes in the family □ increase in stress □ depressed
□ child is a worrier □ perfectionist □ hyperactivity
□ breath-holding spells □ confusion

If your daughter has started her 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: ________________________________