Pediatric Gastroenterology
New Patient Form (birth-5 years)
To be filled out by the parent or guardian

Child’s Name ________________________________
Birth date _____/_____/______ Sex _____

Please check the correct box

I. PREGNANCY AND BIRTH
   1. Any illness during the pregnancy? ........................................... □ no □ yes
      If yes, what? __________________________________________________________
   2. How long was the pregnancy? _________________
   3. Any problems with the delivery? ........................................... □ no □ yes
      If yes, what? __________________________________________________________
   4. What was the birth weight? _________________
   5. Any problems as a newborn? ........................................... □ no □ yes
      If yes, what? __________________________________________________________

II. FEEDING
   1. Was/is the child breast-fed? ........................................... □ no □ yes
   2. Was/is the child formula fed? ........................................... □ no □ yes
      If yes, which ones? ____________________________________________________
   3. Is your child on cow’s milk? ........................................... □ no □ yes
   4. Is your child on baby food? ........................................... □ no □ yes
   5. Is your child on table foods? ........................................... □ no □ yes
   6. Do any foods bother your child? ........................................... □ no □ yes
      If yes, which ones? ____________________________________________________

III. BABY SHOTS
   1. Is your child caught up on baby shots? ........................................... □ no □ yes
      If no, which ones are behind? _________________________________________

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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?

4. Has your child had any serious accidents? □ no □ yes
   If yes, what?

5. Does your child take any medicines? □ no □ yes
   If yes, please list them, and the dose:

V. DEVELOPMENT

Please check the box if the child can:

- □ Smile
- □ Watch objects move
- □ Laugh
- □ Roll over
- □ Sit unsupported
- □ Stand
- □ Walk
- □ Use sentences
- □ Use the toilet
- □ Tricycle
- □ Bicycle
- □ Swim

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. Does anyone in the family have nervous system problems or migraine headaches? □ 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-parent: name________________________ occupation____________________

4. The 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  □ Preschool  □ Other relative

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

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

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

11. Has the child been exposed to toxins? □ no □ yes
If yes, what?_______________________________________________________

12. What games or activities does the child like?
_____________________________________________________________________
_______________________________________________________________________

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 □ unexplained 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 □ noisy breathing □ snoring

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
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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
                     □ child is a worrier  □ perfectionist  □ depressed  □ hyperactivity
                     □ breath-holding  □ confusion

Information Recorded by:  _________________________________
Relationship to Patient:  _________________________________