Pediatric Gastroenterology Health History New Patient Form

PROVIDENCE Children's Health

Patient name: _____ Date of birth: _____ □ Male □ Female

Main symptom you would like to discuss today: _____.

Symptom length:	□ _____days	□ _____weeks	□ _____months	□_____years
Symptom frequency:	□ sometimes	□ daily	□ always	
Most frequent time of day:	□ upon waking	□ daytime	□ evening	□ after eating
	□ at night	□ random		
Symptoms interfere with:	□ eating	□ sleeping	□ school activities	
Other treatments:	□ Medications: _____			
	□ Food changes: _____			
	□ Other: _____			
Other testing: □ None	□ Blood work	□ Urine studies	□ Stool studies	□ Imaging

Other symptoms in the past year □ NONE

□ Poor appetite	□ Weight loss or lack of weight gain	□ Cough that won't go away
□ Nausea	□ Chronic or unexplained fevers	□ Wheezing
□ Vomiting	□ Low energy or feeling tired	□ Hoarse voice
□ Trouble swallowing	□ Headaches	□ Chest pain
□ Heartburn	□ Lightheadedness	□ Irregular heart beat
□ Abdominal pain	□ Chills or night sweats	□ Wetting or urine (pee) accidents
□ Burping more than usual	□ Red or painful eyes	□ Painful urination
□ Gas or bloating	□ Mouth sores	□ Back pain
□ Diarrhea	□ Achy joints	□ Feeling dizzy
□ Constipation	□ Red or swollen joints	□ Bleeding or a lot of bruising
□ Painful stools (poop)	□ Hair loss	□ Irregular periods
□ Soiling or stool accidents	□ Rash	□ Anxiety or stress
□ Blood in stool	□ Bigger lymph nodes	□ Depression or feeling mood

Tell us about your bowel movements

How often: _____times per day OR every_____days

How do they look: □ hard □ lumpy □ smooth and formed □ soft □ loose □ watery

Food and Nutrition

Food restrictions or allergies:	□ None
If child is under 1 year of age:	□ Breastmilk □ Formula: _____ How many ounces per feeding:_____ How many feedings per day: _____

Current Medications □ NONE

Medication	Amount	How many times per day?

PLEASE FILL OUT THE BACK OF THIS FORM.

Pediatric Gastroenterology
History New Patient Form

PROVIDENCE Children's Health

Medication Allergies and Side Effects □ **None**	
Medication	Reaction

Birth History

How was the baby delivered: □ Vaginal □ Caesarean

When was the baby born: □ At term, 38-42 weeks □ Premature, before 37 weeks:_____

What was the baby's weight at birth: _____

Were there any problems during or after mom gave birth?:_____

Other known health problems □ **None**	

Past Surgeries □ **None**		
Surgery	Date	Hospital and Surgeon

Past Hospital Stays □ **None**		
Reason	Dates	Hospital

Social History

Who lives with the patient? _____

Who cares for the patient during the day? _____

School:_____ Grade in school: _____

How does the patient do in school: □ Above average □ Average □ Below Average

Activities/Hobbies/Sports:_____

Pets or animals at home: □ None _____

Do you suspect your child is involved with:

□ Tobacco □ Marijuana □ Sexual Activity

□ Other drugs: _____

Other issues (stresses, divorce, custody, abuse, etc.): _____

Pediatric Gastroenterology
History New Patient Form

PROVIDENCE Children's Health

Family History
Patient's mother is: □ Alive □ Deceased □ Unknown Occupation: _____
Patient's father is: □ Alive □ Deceased □ Unknown Occupation: _____
How many brothers does the patient have? _____
How many sisters does the patient have? _____

Do any of your family members have any of these conditions?

M = Mother
S = Sister
MGM = Maternal Grandmother
MGF = Maternal Grandfather
F = Father
B = Brother
PGM = Paternal Grandmother
PGF = Paternal Grandfather

□ Constipation	_____	□ Rheumatoid Arthritis	_____
□ Irritable Bowel	_____	□ Juvenile Diabetes	_____
□ Lactose Intolerance	_____	□ Lupus	_____
□ Acid Reflux	_____	□ Thyroid disease	_____
□ Stomach Ulcer	_____	□ Psoriasis	_____
□ Celiac Disease	_____	□ Migraines	_____
□ Ulcerative Colitis	_____	□ Seizures	_____
□ Crohn's Disease	_____	□ Depression	_____
□ Gallstones	_____	□ Anxiety	_____
□ Hepatitis B	_____	□ Autism	_____
□ Hepatitis C	_____	□ Eating Disorder	_____
□ Other Liver Disease:	_____	□ Other Mental Illness:	_____
□ Nasal Allergies	_____	□ Adult-Onset Diabetes	_____
□ Asthma	_____	□ Heart Disease	_____
□ Eczema	_____	□ High Blood Pressure	_____
□ Food Allergies	_____	□ High Cholesterol	_____
□ Anemia	_____	□ Colon Polyps	_____
□ Tuberculosis	_____	□ Colon Cancer	_____
□ Problems with Anesthesia	_____	□ Other Cancer:	_____

Is there anything else we should know about the patient and family?

_____

_____

_____