



'Specially For Children-Pediatric Gastroenterology

Patient History Questionnaire

'SFC Account #: _____

Date: _____ Patient's Name (Last, First MI): _____

Date of Birth: _____ Age: _____ yrs. _____ mos.

Informant's name: _____ Relationship to Patient: _____

Informant Signature: _____

Please list the Physician(s) or Person(s) who requested this consultation:

Please indicate the patient's complaints: _____

Please indicate the problems your child is having:

(Please Check Yes or No)	Yes	No		Yes	No
Spits Up			Vomits		
Wont Eat			Losing Weight		
Belly Hurts			Diarrhea		
Bleeding			Constipation		
Stool Accidents			Fever		
Missing School			Liver Problems		
Other Problems			Cries a lot/ Fussy		

Please List other problems:

Immunizations: (circle one)

Are any immunizations needed? Yes No

Any past reactions to immunizations? Yes No

Birth History:

Birth weight: _____ lbs. _____ oz.

Which Hospital was the patient born in? _____

Number of Pregnancies: _____

(circle one)

Was the patient born prematurely? Yes No

Was he/she on a breathing machine? Yes No

Did the patient stay in the Nursery more than 2 days? Yes No

Did the patient have complications during the stay? Yes No

Please list the complications:

Medical History:

Is the patient allergic to any medication? Yes No Which medications? _____

Has the patient ever been hospitalized? Yes No Where/When? _____

Has the patient ever had any operations? Yes No Where/When? _____

Has the patient had any serious illnesses? Yes No Please List: _____

Does the patient take any medications, including Over-the-Counter, regularly? Yes No

If yes, **PLEASE LIST THEM BELOW.** Be sure to include any Nutritional Supplements such as vitamins and any NSAIDs, such as Motrin, Aspirin, Ibuprofen and/or Aleve, etc...

MEDICATION	AMOUNT	HOW OFTEN	REASON

Date: _____ Patient's Name: _____ DOB: _____

Has your child had:

(Please Check Yes or No)	Yes	No		Yes	No
Brain Problems or Seizures			Asthma		
Headaches			Pneumonia		
Eye Problems			Heart Problems		
Ear problems			Stomach Trouble		
Nose Problems			Liver Trouble		
Mouth/Throat Problems			Anemia		
Skin Problems			Food Allergies		
Other Medical Problems			Serious Bleeding		

Please List other problems:

Diet History: What does the patient eat and drink? _____

Are there any food intolerances? _____

Social History:

Are the patient's parents separated/divorced? Yes No

Are you a single parent? Yes No

Does the patient do poorly in school? Yes No Is your child missing school? Yes No

Is the patient involved in special programs/therapies? Yes No If yes, which programs? _____

Family History (family history should include information about brothers/sisters, parents, aunts/uncles, and/or grandparents)

Is there a family history of:

(Please Check Yes or No)	Yes	No		Yes	No
Food or Medicine Allergies			Crohn's Disease or Colitis		
Asthma			Irritable Bowel or Spastic Colon		
Birth Defects			Milk Intolerance		
Cancer in Children			Stomach Ulcers		
Cystic Fibrosis			Intestinal Bleeding		
Celiac Disease			Intestinal Cancer		
Hepatitis			Intestinal Polyps		
Gallstones			Other Intestinal Problems		
Pancreatitis			Thyroid or Other Gland Problems		
Other Kidney Disease(s)			Seizures		
Other Medical Problems					

Are there any other diseases that run in the family?

*Which of these issues present special concern in planning for the patient's healthcare?

-Please check all that apply-

Child care situation Insurance or Other Financial concerns Parent Work Schedule

Other member of household with special needs Other? _____

Please explain the issues you checked above and/or provide additional information about your family that would help us in planning for the patient's health care: