New Patient Form- PedsGastro Center Date:

Name: _____ DOB _____

Allergies (ex: food, seasonal, medications)_____

Current Medications : _____

Reason for the visit

Problems and symptoms _____

Duration of illness _____ Have you seen a doctor _____

Consult requested by _____

If Child less than 3 years old fill in *Birth History:*

Was child full term? _____ premature?_____ If Premature, how many weeks? _____

Child's Birth Weight_____ Vaginal delivery or C Section _____

Were there any complications during pregnancy? _____

Were there any problems during labor and delivery? _____

Was mother on any prescribed or over the counter medications during pregnancy? _____

Did child had first stool within 24 hours of birth? _____

Is/Was child breastfed/ bottle?_____ If breastfed, how long? _____

What kind of formula is/did child drink?_____

Development : Normal/Delayed

Immunization: Up to date: Yes/No

Past History:

Asthma…… yes / no Explain_____

Heart Disease……. yes / no Explain_____

Eczema……yes / no Explain_____

Seizures…….. yes / no Explain_____

Diabetes……..yes / no Explain_____

Liver Disease……... yes / no Explain_____

Cystic Fibrosis ……yes / no Explain_____

High Cholesterol…...yes / no Explain_____

GERD……yes / no Explain_____

IBD……..yes / no Explain_____

Kidney disease .....yes / no Explain_____

Muscular……yes / no Explain_____

Neurological……yes / no Explain_____

Endocrine ……yes / no Explain_____

Others …….. yes / no Explain_____

Any hospitalizations : _____ What year ? _____

Any Surgeries : _____What year? _____

Any Procedures : **_____What year?_____**

Family History

Is there a history of the following illnesses/ diseases/ cancers? If yes please explain who in the family.

(Mother, Father, Sister, Brother, Maternal grandmother(MGM), Maternal Grandfather(MGF), Paternal Grandmother(PGM), Paternal Grandfather(PGF), Maternal aunt and uncle, Paternal aunt and uncle, first cousins maternal and paternal side)

Diabetes……. yes / no Explain_____

Gallstones ……. yes / no Explain_____

Ulcers……..yes / no Explain_____

IBS……. yes / no Explain_____

IBD……. yes / no Explain_____

Pancreatic Cancer… yes/ no Explain_____

Stomach Cancer…… yes/ no Explain_____

Liver Cancer…..... yes / no Explain_____

Pancreatitis…….. yes / no Explain_____

Liver Disease……. yes / no Explain_____

Cystic Fibrosis…….. yes / no Explain_____

Spastic Colon……. yes / no Explain_____

High Cholesterol…. yes / no Explain_____

Colon Cancer……. yes / no Explain_____

Polyps…….. .yes / no Explain_____

GERD…….. yes / no Explain_____

Hiatal Hernia……. yes / no Explain_____

Celiac Disease..... yes / no Explain_____

Asthma……..yes / no Explain_____

Heart Disease……. yes / no Explain_____

Hypertension ……. yes / no Explain_____

Eczema……yes / no Explain_____

Seizures…….. yes / no Explain_____

Kidney disease .....yes / no Explain_____

Muscular……yes / no Explain_____

Thyroid ……yes / no Explain_____

Connective tissue…yes / no Explain_____

Others ……..... yes / no Explain_____

Social History

Who does the child lives with ? _____

Are the parents married?____ Yes ____No Other significant caregivers: _____

Any pets at home? : ____ Yes ____No What kind of pets? _____

Any smoking (inside or outside home)? : ____ Yes ____No

Any recent travel outside USA in last 6 months or one year? ____ Yes ____No

For Children 10 years and above:

Smoking? _____ Yes _____ No

Drinking alcohol? _____ Yes _____ No

Drugs? _____ Yes _____ No

Sexual Activity ? _____ Yes _____ No

School

Grade _____

Has the patient missed a lot of school due to medical complaints? _____ Yes (_____days) _____No

Does your child do well in school ? _____ Yes _____No

Does your child has learning disabilities? _____ Yes _____No

Patient's level of exercise: ____unable due to health ____doesn't ____ once a week

____a couple times per week other_____

Patient participates in: ____ sports ____hobbies ____job(s)

Diet for children 3 years and younger:

Infants : Type of formula or milk?_____ How many ounces per day _____

Baby food/ Cereal _____ How much of juice/fluids _____

Any special diet? _____

Diet for children > 3 years and older:

Meals how many? _____

Fast foods ? _____ How many time s a week? _____

Soda? _____ Juices? _____ Milk? _____

Review of Systems

Please check off which fits best to patient, If yes please explain

Category	Review of Systems	Yes	No	Explain
General	~weight gain or loss ~fatigue ~irritability/crying spells ~fever			
Ear, Nose, Mouth/Throat	~frequent ear/throat/sinus infections ~snoring or noisy breathing ~hoarse voice ~sour taste in mouth ~mouth sores or ulcers			
Eyes	~vision problems			
Skin	~rashes, jaundice or other conditions			
Respiratory	~apnea ~recurrent pneumonia ~chronic wheezing ~chest pain while lying down or with exercise			
Cardiovascular	~heart defect ~irregular or fast heartbeat ~high or low blood pressure			
Gastrointestinal	~nausea ~vomiting (blood tinted or bile stained) ~pain/difficulty in swallowing ~diarrhea ~constipation ~poor appetite ~abdominal pain ~blood or mucus in stool ~black stools			
Neurological	~abnormal behavior ~Seizures ~migraines ~headaches ~spina bifida or meningomyelocele			
Genitourinary	~increased or decreased urine output ~dark urine ~wetting accidents ~change in menstrual periods			
Musculoskeletal	~Muscle weakness ~paralysis ~joint or back pain ~redness/swelling			
Psychiatric	~stress/anxiety/depression			
Others				

Parent/Guardian Signature : _____ Date : _____