

PEDIATRIC GASTROENTEROLOGY ASSOCIATES

Medical Information Regarding Your Child (Page 1/2)

Last Name:	First Name:	Age:
Who does the patient live with?	How many brothers and sisters?	
Pediatrician:	Other doctors involved in the care:	

Why does your child need this appointment?: _____

REVIEW OF SYSTEM

Has the patient ever suffered from OR been diagnosed with any of the following problems?

SYSTEM	NO	YES	SYSTEM	NO	YES	SYSTEM	NO	YES	SYSTEM	NO	YES
Gastrointestinal			Genitourinar			Muscular			Respiratory		
Diarrhea			Kidney disease			Muscle pain			Asthma		
Constipation			Urine infection			Joint Pain			Choking		
Abdominal pain			Urine accidents			Back pain			Chronic Cough		
Nausea			Ear, Nose & Throat			Neck pain			Hoarseness		
Vomiting			Nosebleeds			Psychosocial			Pneumonia		
Rectal bleeding			Deafness			Depression			Endocrine		
Trouble Swallowing			Canker sores			Anxiety disorder			Diabetes		
Heartburn			Chronic sinusitis			Substance Abuse			Thyroid disorders		
Soiling			Blood			Alcoholism			Cardiac		
Jaundice			Bleeding disorder			Eye			Blood Pressure		
Bloating			Anemia			Blindness			Murmur		
General			Neurology			Cataracts			Chest pain		
Dizziness			Seizures			Glaucoma			Birth History		
Fatigue			Migraines			Skin			Normal		
Nighttime sweating			Cerebral Palsy			Rash			Premature		
Weight loss			Weakness			Bruises			Any complication?		
Loss Appetite			Headache			Eczema					
Fever						Hives					

LABORATORY TESTS

Please indicate if your child had any of the following medical tests done:

TEST	NO	YES	Test	NO	YES		NO	YES
Blood			MRI			Liver Biopsy		
Stools			X Ray			Skin tests		
Urine			Procedure			Breath tests		
Ultrasound			Endoscopy					
CT scan			Colonoscopy					

Medical Information Regarding Your Child (Page2/2)

PAST HISTORY

Please explain YES answers in details description in the box provided

	NO	YES		
Any Allergy? (Including medications, food, environmental)			Names of medications:	
Any surgeries?			Surgery:	Date:
Any hospitalization?			Reason:	Date:
Currently on any medications?			Names:	Dosage:
Any milk daily?			Amount per day:	

FAMILY HISTORY

Please indicate if parents/siblings/grandparents have any of the following and indicate relationship to patient:

DISEASE	NO	YES	DISEASE	NO	YES	DISEASE	NO	YES
Ulcerative Colitis			Stomach ulcer			Cystic Fibrosis (CF)		
Crohn's disease			Helicobacter pylori infection			Thyroid disease		
Polyps			Intestinal/Stomach Cancer			Diabetes type 1 (insulin depend)		
Hepatitis			Intestinal Lymphoma			Blood disorder		
Liver disease			Liver cancer			Autoimmune disease		
Jaundice			HIV / AIDS			Arthritis		
Gallbladder disease			Tuberculosis			Psychiatric disease		
Celiac disease			Food Allergy			Behavioral disease		
GERD (Reflux)			Asthma					
Irritable Bowel Syndrome (IBS)			Eczema					
Constipation			Skin Diseases					

Person completing this form: _____

For office only

Physician Signature _____ **Date:** _____