

**James Whitcomb Riley Hospital for Children
Pediatric Gastroenterology/Hepatology/Nutrition**

This will be a part of your medical record. Please make sure it is readable. Thank you.

Date _____ Phone _____

Patient Name _____

Address _____

Chief Complaint or why you are here? _____

Has the patient been seen by a specialist before for this? Who? _____

Birth History: Hospital _____ Length _____ Weight _____

Full Term/Premature (circle one) Labor/Delivery: Vaginal/C-section (circle one)

Describe any problems: _____

Immunizations up to date: Yes No

Feeding History :

How was your child fed as an infant? Breast-fed How long? _____ Bottle-fed Formula _____

Is your child on a special or restricted diet? Yes No If yes, please describe: _____

Is your child's appetite normal or decreased? _____

Stool History:

Did your child pass meconium (stool) while in the nursery in the first 24-48 hours of life? Yes No

Did your child have normal stools as a baby? Yes No How often does your child pass stool? _____

Does your child have accidents? Yes No

What is the consistency of your child's stool? Hard Soft Loose Watery

Previous illnesses/List any serious medical problems that your child has:

Previous surgeries/hospitalizations include age, hospital, reason for hospitalization:

Please list all medications the child is currently taking. Please give the dose and the reason taking.

Medication	Dose	Frequency	Reason

Allergies/Reactions:

Does the patient smoke? _____ Who if anyone smokes in the home? _____

Do you have well water or city water?(circle one) What kind of animals are in the home? _____

Who lives in the house with the patient? (Please include the relationship)

Name:	Age	Relation:	Any health problems	Occupation

What grade is the child in? _____ What grades does the child get in school? _____

Recent change in behavior/performance? _____

Any stressful events. _____

Please indicate if anyone in the patient's family (or relative) had any of the following? If yes, list the person's relationship to the patient next to the problem.

<input type="checkbox"/> Migraine	<input type="checkbox"/> Liver Problems	<input type="checkbox"/> Lactose Intolerance	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Seizures	<input type="checkbox"/> Bleeding Problems/ Hemophilia	<input type="checkbox"/> Irritable bowel syndrome/spastic colon	<input type="checkbox"/> High cholesterol or triglycerides
<input type="checkbox"/> Polyps	<input type="checkbox"/> Depression	<input type="checkbox"/> Ulcerative colitis	<input type="checkbox"/> Early heart attacks or strokes
<input type="checkbox"/> Colon Cancer	<input type="checkbox"/> Anemia	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Hypertension
<input type="checkbox"/> Celiac Disease	<input type="checkbox"/> Acid Reflux/GERD	<input type="checkbox"/> Crohn's disease	<input type="checkbox"/> Obesity
<input type="checkbox"/> Gallstones	<input type="checkbox"/> Constipation	<input type="checkbox"/> Pancreatitis	<input type="checkbox"/> Diabetes

Is there any other disease/illness that runs in the family? _____

Review of Systems: Please check any of the following that are problems for your child:

Information helpful to list: Location, severity, duration, timing, context, quality, and/ or signs.

General

- Recurrent fevers
- Weight loss
- Weight gain

Skin

- Rashes (including eczema)
- Acne
- Easy bruising

Ears, Nose, Throat

- Ear pain
- Ear Infections
- Discharge from ears
- Nose bleeds
- Sinus problems
- Mouth Ulcers
- Hoarseness
- Sour taste in mouth
- Sore throat
- Dental problems
- Trouble swallowing

Gastrointestinal (Stomach/Intestine)

- Difficulty swallowing
- Heartburn
- Vomiting_/spitting up
- Nausea
- Stomach pain
- Diarrhea
- Constipation (hard or infrequent stools)
- Soiling underpants
- Blood in stool
- Liver problems/jaundice/hepatitis
- Unexplained itching

All others reviewed and are negative

Heart/Blood vessels

- Heart murmur
- Heart problems
- Chest pain
- Palpitations (fast heart beat)
- Irregular heart beat
- Blood pressure problems

Genital/Urinary System

- Pain/burning with urination
- Blood in urine
- Increased frequency/amount urine
- Swelling/retaining water
- Menstrual problems
- Other urinary tract/kidney problems

Endocrine (glands)

- Thyroid problems
- Poor growth
- Other hormone/gland problems

Neurologic (Brain/Nerves)

- Developmental Delay
- Headaches
- Seizures
- Dizziness
- Fainting
- ADHD (hyperactivity)
- Decreased sensation
- Decreased muscle strength
- Other neurologic problems
- Depression
- Anxiety

Breathing/Lungs/Chest

- Coughing
- Wheezing
- Asthma
- Shortness of Breath
- Pneumonia
- Apnea (stops breathing)

Breasts

- Discharge from nipples
- Breast lumps/masses
- Other skin problems

Musculoskeletal

- Joint problems/pain
- Weakness
- Scoliosis (curved spine)

Allergy/ Immune System

- Allergies
- Immune problems
- Frequent infections
- Unusual infections

Eyes

- Wear glasses
- Blurry vision
- Double vision
- Eye pain

Hematologic (Blood Problems)

- Bleeding disorders/ easy bleeding
- Anemia
- Received blood transfusions
- Easy bruising
- Swollen lymph nodes
- Lumps/growths

Staff Physician Signature: _____

Date: _____

Parent/Guardian initial that you reviewed or updated information on follow up visits. Staff MD sign that you also reviewed.

Parent/Guardian

Physician signature

_____ Date: _____

_____ Date: _____

_____ Date: _____

_____ Date: _____

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