Patient Name _____ Date of Birth _____ Today's Date _____

Pediatric Gastroenterology Associates of Houston
New Patient Questionnaire

Birth History

What hospital/birth center? _____

C-section or vaginal delivery? ◯ c-section ◯ vaginal

What was the birth weight? _____

What was the baby's gestational age at birth? _____

How long was the baby in the hospital? _____

Please list any problems/complications:

Past Medical History

Please list the patient's current medical problems: ☐ None

Please list all surgeries in the patient's lifetime: ☐ None

Surgery:	Date:	Surgeon:

Please list the patient's current medications (if additional room is needed, please provide attached list): ☐ None

Name: ☐ See attached.	Frequency/Dose/Strength:

Please list any allergies (medication, food, other): ☐ None

Please list any other medical specialists the patient has seen (ENT, allergist, cardiologist, etc.)

How many days of school did the patient miss in the last year for illness? _____

What is the name of your current home health care company? _____

Please list any special home medical equipment (oxygen, feeding pump, apnea monitor, etc.)

Family History

Please list the patient's siblings: ☐ None

Name:	Birth Date:	Gender:
		◯ M ◯ F
		◯ M ◯ F
		◯ M ◯ F
		◯ M ◯ F
		◯ M ◯ F

Does any one in the family have any of the following conditions (please check all that apply):

☐ Crohn's Disease ☐ Ulcerative Colitis ☐ Lupus
☐ Rheumatoid Arthritis ☐ Stomach Ulcers ☐ Celiac Disease
☐ Congenital Disease ☐ Type I Diabetes ☐ Migraines

Social History

Does patient attend any type of daycare? ☐ Yes ☐ No

Does anyone the patient knows smoke? ☐ Yes ☐ No

Please list any pets in the home, or other animals to which the patient is exposed. ☐ None

Who lives with the patient at home?

What grade is the patient currently in? _____

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Has the patient recently traveled? ☐ No
If so, where and when?

Has the patient eaten foreign foods or unpasteurized dairy products? If so, what and when? ☐ No

Review of Systems

Constitutional

Fever or chills (recent, or recurrent)	☐ Yes	☐ No
Night sweats	☐ Yes	☐ No
Weight ◯ loss or ◯ gain	☐ Yes	☐ No
Decreased energy	☐ Yes	☐ No
Appetite changes	☐ Yes	☐ No
Difficulty gaining weight	☐ Yes	☐ No
Difficulty sleeping	☐ Yes	☐ No

Eye

Vision Problems	☐ Yes	☐ No
Yellow eyes	☐ Yes	☐ No

Skin

Jaundice	☐ Yes	☐ No
Rash	☐ Yes	☐ No

Neurological

Frequent headaches	☐ Yes	☐ No
Convulsions or seizures	☐ Yes	☐ No
Developmental delays	☐ Yes	☐ No
Is or was your child enrolled in ECI	☐ Yes	☐ No
Does your child require special classes in school	☐ Yes	☐ No
Does your child require therapy	☐ Yes	☐ No

If yes, please identify
◯ Speech ◯ Language ◯ Physical ◯ Occupational

Cardiovascular

Heart murmur or heart problem	☐ Yes	☐ No
Chest pain	☐ Yes	☐ No
Exercise limitation	☐ Yes	☐ No
Fainting Spells	☐ Yes	☐ No

Gastrointestinal

Diarrhea	☐ Yes	☐ No
Difficulty swallowing	☐ Yes	☐ No
Vomiting or excessive spit up	☐ Yes	☐ No
Constipation	☐ Yes	☐ No
Heart burn	☐ Yes	☐ No
Frequent abdominal pain	☐ Yes	☐ No
History of iron or other nutritional deficiency	☐ Yes	☐ No
Mouth sores	☐ Yes	☐ No
Blood in stools	☐ Yes	☐ No
White stools	☐ Yes	☐ No

Allergic/Immunologic

Eczema (dry, rough, or itchy skin)	☐ Yes	☐ No
Hives (urticaria)	☐ Yes	☐ No
Allergies (allergic rhinitis, hay fever, etc.)	☐ Yes	☐ No

Endocrine

Too hot or too cold	☐ Yes	☐ No
Blood sugar problems (including diabetes)	☐ Yes	☐ No
Easy bruising / bleeding	☐ Yes	☐ No
Take birth control pills	☐ Yes	☐ No

Psychiatric

Symptoms of anxiety (excessive worries)	☐ Yes	☐ No
Symptoms of depression (hopeless, helpless, excessive sadness, crying)	☐ Yes	☐ No
Behavioral problems (fighting at school)	☐ Yes	☐ No
Other psychiatric conditions	☐ Yes	☐ No

Musculoskeletal

Joint pain or swelling	☐ Yes	☐ No
Muscle weakness	☐ Yes	☐ No

Other

Please note any other important symptoms not listed above:

_____

_____

_____

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