Children's Gastroenterology MCSG
EXPERT CARE FOR EVERY CHILD

Sarah Sela, MD Stephanie Abrams, MD Roy Nattiv, MD Leon Chen, MD Sonia Michail, MD

PEDIATRIC GASTROENTEROLOGY PATIENT HISTORY FORM

Please help us get to know you and your child better by providing us with the following information.

Pt name: _____ ***DOB:*** ___/___/_____

Mother/Guardian	**Occupation**	**Does your child have any siblings?**
Father/Guardian	**Occupation**	**Who does the patient live with?**
Primary Care Physician/Pediatrician **Phone:** **Fax:**		**Other doctors involved in your care:**

Review of Systems: *Please help us understand your child's health history by answering the following questions.*
Has your child ever been diagnosed with any of the following? If YES, please check any that apply and explain in the space provided.

SYSTEM	YES	NO	SYSTEM	YES	NO	SYSTEM	YES	NO	SYSTEM	YES	NO
Birth History			Heart			Endocrine/ Metabolic			Skin		
Birth Wt:			High blood pressure			Diabetes			Rash		
Normal			Low blood pressure			Thyroid disease			Lesions		
Premature			Irregular heartbeat			Brain/Neurological			Dietary		
Caesarean			Chest pain			Seizures			Restricted diet		
Ventilator			Lungs			Weakness			Weight loss		
Intestinal/ GI issues			Asthma			Headaches			Obesity		
Diarrhea			Pneumonia			Migraines			Food allergies		
Constipation			Chronic cough			Blind/deaf			Psychosocial		
Rectal bleeding			Hoarseness			Cerebral palsy			Depression		
Heartburn			Kidney/ Urinary			Mental retardation			Anxiety		
Trouble swallowing			Kidney disease			Blood/ Bleeding			Alcoholism		
Nausea			Frequent urine infection			Hemophiliac			Substance Abuse		
Vomiting			Pain with urination			Easy bruising			Other		
Abdominal pain			Bedwetting			Sickle Cell					
Jaundice											
Liver disease											

Please continue on the next page

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Past Medical History: *Please answer the following questions about your child's past medical problems.*

Please explain any YES answers in detailed description in the box provided

Have he/she ever had any surgery or been hospitalized? __No __Yes, Please explain Have he/she had any problems with anesthesia? __No __Yes, please explain:	Surgeries: (Please also provide dates)	Hospitalizations other than surgery:
Is he/she currently taking any medications or vitamins?	Please list medications: 1. 2. 3. 4.	Drug Allergies:

Family History: *Please indicate if you or your spouse, your parents, family members, and/or children ever had any significant medical conditions:*

	Age	Medical problems
Mother		
Father		
Siblings 1. 2.		
Grandparents: 1. 2.		

Social History: *Please answer the following about your child's home environment*

Grade in school:	**Hobbies:**	**Extracurricular activities:**
Tobacco use in the house? __No __Yes	**Alcohol use?** __No __Yes	**Pets:**

Please feel free to provide your GI specialist with any additional information that you think is important in allowing them to get to know you and your child better.

Person completing this form _____ Relationship to patient _____ Date _____

Reviewed by provider _____ Date _____