Hasbro Children's Hospital
A Lifespan Partner

Pediatric Gastroenterology
New Patient Form (over 12 years)
TO BE FILLED OUT BY THE PATIENT

Name _____

Birth date _____ Sex _____

I. BIRTH Please check box that applies

1. Any problems as a newborn?..... ☐ no ☐ yes

If yes, what?_____

II. NUTRITION

1. Do any foods bother you?..... ☐ no ☐ yes

If yes, what?_____

2. Are you on a special diet?..... ☐ no ☐ yes

If yes, what type?_____

III. IMMUNIZATIONS

1. Are you caught up on immunizations?..... ☐ no ☐ yes

If not, which ones are missing?_____

IV. SCHOOL

1. What grade are you in? _____
2. Are there any problems at school?..... ☐ no ☐ yes

If yes, what?_____

3. What do you plan to do when you graduate?

_____

V. PAST MEDICAL HISTORY

1. Have you ever had surgery?..... ☐ no ☐ yes

If yes, what kind?_____

_____

2. Do you have any chronic illnesses?..... ☐ no ☐ yes

If yes, which ones?_____

3. Have you had to stay in the hospital?..... ☐ no ☐ yes

If yes, why?_____

_____

4. Have you had any serious accidents?..... ☐ no ☐ yes

If yes, what?_____

5. Do you take any medicines?..... ☐ no ☐ yes

If yes, please list them, and the dose:_____

6. Do you have any allergies? ..... ☐ no ☐ yes

If yes, what? _____

VI. FAMILY HISTORY

1. Does anyone in the family have bowel, colon, stomach liver, gall bladder, esophagus, or pancreas problems?..... ☐ no ☐yes

If yes, who and what? _____

_____

2. Anyone in the family with nervous system problems or migraines? ☐ no ☐ yes

If yes, who and what?_____

3. Are there any allergies in the family?..... ☐ no ☐ yes

If yes, who and

what?_____

4. Does anyone in the family have other serious health problems?... ☐ no ☐ yes

If yes, who and what?_____

_____

VII. SOCIAL HISTORY

1. Mother: name_____ occupation_____
2. Father: name_____ occupation_____
3. Step- name_____ occupation_____

parents: name_____ occupation_____

4. Your Brothers and Sisters:

Name	Age	Name	Age
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

5. How many people live in the home?

Adults _____ Children _____

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(CONTINUED)

6. With whom do you live? (Check box)

☐ both parents ☐ mother ☐ father ☐ guardian ☐ other

7. Have you traveled out of the US in the past year? ..... ☐ no ☐ yes
   If yes, where?_____

8. Are you around animals or pets?..... ☐ no ☐ yes
   If yes, which?_____

9. Do you drink well water?..... ☐ no ☐ yes

10. Have you been exposed to toxins?..... ☐ no ☐ yes
    If yes, what?_____

11. What hobbies, activities, sports, or groups do you participate in?
    _____

12. Do you have a job?.....;.....☐ no ☐ yes
    If yes, what?_____

13. Are you sexually active?..... ☐ no ☐ yes
    If yes, do you use birth control?..... ☐ no ☐ yes
    If yes, what type?_____

14. Do you smoke or use other tobacco products?..... ☐ no ☐ yes

15. Do you drink alcoholic beverages?..... ☐ no ☐ yes

SYSTEMS REVIEW Please check all that apply.

General: ☐ poor appetite ☐ excessive appetite ☐ excessive thirst ☐ overweight
☐ underweight ☐ weight loss ☐ too tall ☐ too short
☐ difficulty sleeping ☐ excessive sleeping ☐ no energy ☐ fevers ☐ chills

Skin: ☐ rash ☐ lump ☐ easy bruising or bleeding ☐ itching ☐ jaundice

Eyes: ☐ eye pain ☐ blurred vision ☐ wears glasses ☐ recent change in vision

Ear-Nose-Throat: ☐ earaches ☐ decreased hearing ☐ frequent nosebleeds
☐ bad teeth ☐ trouble swallowing ☐ sore throat ☐ canker sores
☐ chronic runny nose

Respiratory: ☐ hoarseness ☐ cough ☐ wheezing ☐ difficulty breathing
☐ shortness of breath attacks

Cardiovascular: ☐ chest pain ☐ heart murmur ☐ high blood pressure
☐ heart trouble

Gastrointestinal: ☐ abdominal pain ☐ nausea ☐ vomiting ☐ indigestion
☐ heartburn ☐ bloating ☐ diarrhea ☐ constipation ☐ blood in stools
☐ stools in underwear (soils)

Urinary: ☐ painful urination ☐ increased frequency of urination
☐ daytime wetting ☐ bedwetting

Skeletal: ☐ back pain ☐ limp ☐ swollen joints ☐ swollen arms or legs
☐ joint pain

Neuromuscular: ☐ headache ☐ migraine ☐ weakness ☐ paralysis
☐ numbness ☐ loss of balance ☐ dizziness ☐ fainting
☐ unexplained movements or jerks ☐ convulsions ☐ staring spells

Behavioral: ☐ recent changes in the family ☐ increase in stress
☐ are you a worrier ☐ perfectionist ☐ depressed ☐ hyperactive
☐ breath-holding spells ☐ confusion

If you have started your menstrual periods, complete the following:

When did they begin? Month _____ Year_____

Check any that apply: ☐ painful periods ☐ excessive bleeding
☐ other menstrual problems

Information Recorded by: _____

Relationship to Patient: _____