Hasbro Children's Hospital
A Lifespan Partner

Pediatric Gastroenterology
New Patient Form (6 years - 12 years)
To be filled out by the Parent or Guardian

Name _____

Birth date _____ Sex _____

I. PREGNANCY AND BIRTH Please check the box that applies

1. Any problems during the pregnancy, delivery or after delivery?.... ☐ no ☐ yes

If yes, what?_____

_____

2. Any problems as a baby?..... ☐ no ☐ yes

If yes, what?_____

_____

II. NUTRITION

1. Do any foods bother your child?..... ☐ no ☐ yes

If yes, what?_____

2. Is your child on a special diet?..... ☐ no ☐ yes

If yes, what type?_____

III. IMMUNIZATIONS

1. Is your child caught up on immunizations?..... ☐ no ☐ yes

If no, which ones are behind?_____

IV. PAST MEDICAL HISTORY

1. Has your child ever had surgery?..... ☐ no ☐ yes

If yes, what kind?_____

_____

2. Does your child have any chronic illnesses?..... ☐ no ☐ yes

If yes, which ones?_____

_____

3. Has your child had to stay in the hospital?..... ☐ no ☐ yes

If yes, why?_____

4. Has your child had any serious accidents?..... ☐ no ☐ yes

If yes, what?_____

5. Does your child have any allergies?..... ☐ no ☐ yes

If yes, please list them: _____

_____

6. Does your child take any medications?..... ☐ no ☐ yes

If yes, please list them and the dose: _____

_____

V. DEVELOPMENT

1. Does your child have developmental problems?..... ☐ no ☐ yes

If yes, what?_____

2. What grade is your child in?_____

3. Are there any problems with school?..... ☐ 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 _____

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(CONTINUED)

_____

4. Your Child's Brothers and Sisters:

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

5. How many people live in the child's home? Adults _____ Children _____
6. With whom does the child live? (Check box)
   ☐ both parents ☐ mother ☐ father ☐ guardian ☐ other
7. Does the child spend regular time with (Check box)
   ☐ Sitter ☐ Daycare ☐ Other relative
8. Has the child traveled out US in the past year? ..... ☐ no ☐ yes
   If yes, where?_____
9. Is your child around animals or pets?..... ☐ no ☐ yes
   If yes, which?_____
10. Does your child drink well water?..... ☐ no ☐ yes
11. Has your child been exposed to toxins?..... ☐ no ☐ yes
    If yes, what?_____
12. What hobbies, activities, sports, or groups does your child participate in?
    _____
    _____

SYSTEMS REVIEW Please check all that apply to the child.

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

Cardiovascular: ☐ chest pain ☐ 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 ☐ unexplained movements or jerks
☐ convulsions ☐ staring spells ☐ fainting

Behavioral: ☐ recent changes in the family ☐ increase in stress ☐ depressed
☐ child is a worrier ☐ perfectionist ☐ hyperactivity
☐ breath-holding spells ☐ confusion

If your daughter has started her 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: _____