Hasbro Children's Hospital
A Lifespan Partner

Pediatric Gastroenterology
New Patient Form (birth-5 years)
To be filled out by the parent or guardian

Child's Name _____

Birth date _____/_____/_____ Sex _____

Please check the correct box

I. PREGNANCY AND BIRTH

1. Any illness during the pregnancy?..... ☐no ☐ yes

   If yes, what?_____

2. How long was the pregnancy? _____
3. Any problems with the delivery?.....☐ no ☐ yes

   If yes, what?_____

4. What was the birth weight?_____
5. Any problems as a newborn?..... ☐ no ☐ yes

   If yes, what?_____

II. FEEDING

1. Was/is the child breast-fed?..... ☐ no ☐ yes
2. Was/is the child formula fed?..... ☐ no ☐ yes

   If yes, which ones?_____

3. Is your child on cow's milk?..... ☐ no ☐ yes
4. Is your child on baby food?..... ☐ no ☐ yes
5. Is your child on table foods?..... ☐ no ☐ yes
6. Do any foods bother your child?..... ☐ no ☐ yes

   If yes, which ones?_____

III. BABY SHOTS

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

   If no, which ones are behind?_____

Implemented 3/1/00 Cost Center 4038

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 take any medicines?..... ☐ no ☐ yes

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

   _____

   _____

V. DEVELOPMENT Please check the box if the child can:

☐ Smile ☐ Watch objects move ☐ Laugh ☐ Roll over ☐ Sit unsupported ☐ Stand

☐ Walk ☐ Use sentences ☐ Use the toilet ☐ Tricycle ☐ Bicycle ☐ Swim

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. Does anyone in the family have nervous system problems or migraine headaches?..... ☐ no ☐ yes

   If yes, who and what?_____

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

   If yes, who and what?_____

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(CONTINUED)

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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-parent: name_____occupation_____
4. The 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 ☐ Preschool ☐ Other relative

8. Has the child traveled out of the US in the past year?..... ☐ no ☐ yes
   If yes, where?_____

9. Is the child around animals or pets?..... ☐ no ☐ yes

   If yes, which?_____

10. Does the child drink well water?..... ☐ no ☐ yes

11. Has the child been exposed to toxins?..... ..☐ no ☐ yes

If yes, what?_____

12. What games or activities does the child like?

_____

_____

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 ☐ unexplained 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 ☐ noisy breathing ☐snoring

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

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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 ☐ child is a worrier ☐ perfectionist ☐ depressed ☐ hyperactivity ☐ breath-holding ☐confusion

Information Recorded by: _____

Relationship to Patient: _____