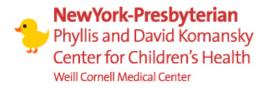
## **Pediatric Gastroenterology & Nutrition**

Telephone:



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# FOLLOW UP VISIT QUESTIONNAIRE

Please complete this questionnaire. It will be an important part of your child's medical record.

Complete Your Child's Name:	
Child's DOB:	Child's Age:

**Pediatrician's Name:** 

Pediatrician's Address:

What is the reason for your child's visit today?

#### **A. Current Medical History**

1) List all medications (include over the counter and herbal therapies).

<b>Current Medications</b>	Dose	How often

2. List any hospitalizations that your child has had. Include his/her age, where hospitalized, and the reason for the hospitalization.

3. Drug/Medication Allergies: \_\_\_\_\_ Food Allergies: \_\_\_\_\_

4. Are your child's immunizations up to date?  $\Box$  Yes  $\Box$  No

5. List any **RECENT** surgeries/procedures with the dates performed that your child has had. Include those done as an outpatient.

#### **B.** Family History

1. Has anyone in the patient's family (or relative) had any of the following? If yes, check the box and list the person's relationship to the patient next to the problem.

Migraine headaches Seizures

- Mental retardation/developmental delay
- Asthma, Emphysema
- Cystic Fibrosis
- Sickle cell disease or trait
- Cancer (list type)

High blood pressure Heart disease or stroke Diabetes Anemia High cholesterol Constipation Polyps

Gallstones/ gall bladder problem Gastritis/ulcer Colitis, Crohns disease Celiac disease Liver problems Blood in stool ☐ Irritable bowel syndrome

2. Is there any other disease/illness that runs in the family?\_

#### C. Social History: (ANY RECENT CHANGES)

1. Who lives in the same household as the patient?

Name	Age	Relationship to patient	Any health problems

2. Are the parent(s):	Single	Married
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Separated Divorced

Remarried

3. School History:

A) Grade in school:B) Performance/Grades

C) Recent change in behavior/performance?

4. Any unusual stresses at home or school? 🗌 Yes

Age at first menstrual period \_\_\_\_\_\_
Date of last menstrual period \_\_\_\_\_\_

If yes, please explain.

## D. Child's Review of Systems: Please check any of the following that are problems *for your child*:

🗌 No

### (IF NOTHING IS CHECKED IT IS ASSUMED TO BE NEGATIVE)

General	Heart/ Blood vessels	<u>Gastrointestinal (Stomach/ Intestines)</u>
U Weight change	Chest pain	Heartburn
E Fever	Palpitations (fast heart beat)	Nausea
Chills	Extremity swelling	□ Vomiting or spitting up
□ Night sweats	☐ Fainting	Abdominal pain
Poor appetite	Irregular heart beat	Diarrhea
Fatigue	Blood pressure problems	Constipation (hard OR infrequent stool)
		Reflux
Eyes	<b>Breathing/Lungs/Chest</b>	Blood in vomit
Vision change	Shortness of breath	Blood in stool
Eye pain	Cough	Liver problems or hepatitis
	Coughing up blood	☐ Jaundice (yellowing of skin)
<u>Ear, Nose, Throat</u>	☐ Wheezing	
🗌 Ear pain	Snoring	Musculoskeletal (Bones/muscles)
Ear infections	Apnea (stops breathing)	☐ Joint pain (knees, wrist, fingers, hips, etc)
□ Nasal congestion	Asthma	Muscle pain
Bloody nose	Pneumonia	Fractures (broken bones)
Mouth sores/ulcers		Bone pain
Trouble swallowing	<u>Skin</u>	
Dental problems	Rash	Breasts
Sour taste in mouth	Hair loss	☐ Nipple discharge
Hoarseness	Eczema	Breast lumps/masses
Genital/Urinary System		Hematology/Blood
Increased urine frequency		Easy bleeding
Urgency		Easy bruising
Urinating at night		Anemia
Blood in urine		Thalassemia
Pain with urination		Received blood transfusions
Genital lesions		Swollen lymph nodes
Absent periods		Bleeding problem/disorder
Menstrual problems		

Neurological   Weakness   Headache   Memory loss   Seizures   Vertigo or dizziness   Tremor   Tingling   Developmental delay   ADHD (hyperactivity)   Decreased sensation   Decreased sensation   Curved spine     Endocrine   Thyroid problems   Always feel hot   Always feel cold   Increased urination   Increased thirst   Poor growth   Diabetes	Allergy/Immune systen         Hives         Anaphylaxis         Lip swelling         Skin feels tight         Morning stiffness         Raynaud's syndrome         Frequent infections         Unusual infections         Depressed mood         No longer do activities you enjoy         Anxiety         Thoughts of suicide (hurting yourself)         Hallucination
E. Feeding History:	
Is your child's appetite normal, increased or decreased?	
<ul> <li>F. Stooling history:</li> <li>How often does your child stool now?</li> <li>When was your child's last bowel movement?</li> <li>Does your child have accidents (soils underpants)?</li> <li>Is your child's stool malodorous (smells worse than normal)?</li> <li>What is the consistency of your child's stool?</li></ul>	
Parent/Patient Signature	Date
Physician Signature	Date

# **Pharmacy Information**

So that you and your physician may take advantage of e-prescribing, we need you to provide information on the pharmacy that you choose to use to fill you or your child's prescriptions. Electronic prescription requests are more efficient, accurate and cost effective. Feel free to speak with your physician if you have additional questions.

Update

Date:

Patient Name:

NYH #:

PRIMARY

Pharmacy Name:

Address:

Phone Number:

Fax Number:

# **SECONDARY** (if applicable)

Pharmacy Name:

Address:

Phone Number:

Fax Number: