Pediatric Gastroenterology & Nutrition

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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: Telephone:

A. Current Medical History

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

Drug	**Dose**	**How often**

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

Drug Allergies:

3. Are immunizations up to date? ☐ Yes ☐ No

4. 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 with the patient?

Name	Age	Relationship to patient	Any health problems

2. Are the parent(s): ☐ Single ☐ Married ☐ 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 ☐ No

If yes, please explain.

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

***(IF* NOTHING IS CHECKED IT IS ASSUMED NEGATIVE.)**

General
- ☐ Recurrent fevers/temperatures
- ☐ Weight loss
- ☐ Weight gain

Skin
- ☐ Skin rashes
- ☐ Acne
- ☐ Easy bruising

Ears, Nose, Throat
- ☐ Ear pain
- ☐ Ear infections
- ☐ Discharge from ears
- ☐ Nose bleeds
- ☐ Sinus problems
- ☐ Mouth Ulcers
- ☐ Trouble swallowing
- ☐ Hoarseness
- ☐ Sour taste in mouth
- ☐ Sore throat
- ☐ Dental problems

Heart/ Blood vessels
- ☐ Heart murmur
- ☐ Heart problems
- ☐ Chest pain
- ☐ Palpitations (fast heart beat)
- ☐ Irregular heart beat
- ☐ Blood pressure problems

Genital/Urinary System
- ☐ Pain/burning with urination
- ☐ Blood in urine
- ☐ Increased frequency or amount of urine
- ☐ Swelling/retaining water
- ☐ Other urinary tract or kidney problems
- ☐ Menstrual problems
- ☐ Age at first menstrual period
- ☐ Date last menstrual periodended

Endocrine (Glands)
- ☐ Thyroid problems
- ☐ Poor growth
- ☐ Other hormone/gland problems

Breathing/ Lungs/ Chest
- ☐ Coughing
- ☐ Wheezing
- ☐ Asthma
- ☐ Shortness of breath
- ☐ Apnea (stops breathing)
- ☐ Pneumonia

Breasts
- ☐ Discharge from nipples
- ☐ Breast lumps/masses
- ☐ Other skin problems

Musculoskeletal
- ☐ Joint problems
- ☐ Weakness
- ☐ Scoliosis (curved spine)

Allergy/Immune System
- ☐ Allergies
- ☐ Immune problems
- ☐ Frequent infections
- ☐ Unusual infections

Gastrointestinal (Stomach / Intestines)
- ☐ Constipation (hard or infrequent stools)
- ☐ Soiling underpants
- ☐ Diarrhea
- ☐ Vomiting/spitting up
- ☐ Heartburn
- ☐ Blood in stool
- ☐ Difficulty swallowing
- ☐ Stomach pain
- ☐ Nausea

Neurologic (Brain / Nerves)
- ☐ Developmental delay
- ☐ Headaches
- ☐ Seizures
- ☐ Dizziness
- ☐ Fainting
- ☐ ADHD (hyperactivity)
- ☐ Decreased sensation
- ☐ Decreased muscle strength
- ☐ Other neurologic problems

Hematologic (Blood problems)
- ☐ Anemia
- ☐ Received blood transfusions
- ☐ Easy bruising
- ☐ Swollen lymph nodes
- ☐ Bleeding disorders/easy bleeding

☐ Liver problems/jaundice/hepatitis

E. Feeding History:

Is your child's appetite normal or decreased?

F. Stooling history:

How often does your child stool now?

When was your child's last bowel movement?

Does your child have accidents (soils underpants)? ☐ Yes ☐ No

Is your child's stool malodorous (smells awful)? ☐ Yes ☐ No

What is the consistency of your child's stool? ☐ Hard ☐ Soft ☐ Loose ☐ Watery

What is the color of your child's stool? ☐ Brown ☐ Yellow ☐ Green ☐ Orange ☐ Red ☐ Black

X

Parent/Patient Signature **Date**

X

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: