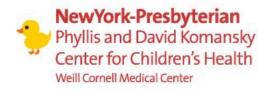
Pediatric Gastroenterology & Nutrition



Weill Cornell Medical Center New York Presbyterian Hospital 505 E 70th Street 3rd Floor New York, NY 10021

Phone: 646-962-3869 Fax: 646-962-0246 **Robbyn Sockolow**, **MD** Director, Pediatric GI

Elaine Barfield, MD Kimberley Chien, MD Thomas Ciecierega, MD Aliza Solomon, DO

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:		
Self Referral Consultation By Dr.			
A. Past Medical History 1. Birth History: Birth Weight:	Length: Place of birth:	Full Term Premature	
Pregnancy problems:			
Labor/Delivery: Vaginal C-section Describe any problems:			
Problems in the Nursery/1 st month of life: 2. List all medications (include over the counter and herbal therapies and vitamins).			
Drug	Dose	How often	

List any medical problems that your child has.

1. 2.

3.

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

Drug Allergies:

4. Are immunizations up to date?	Yes	No No
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5. List any 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.

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Migraine headaches	🗌 High bloo
Seizures	Heart dis
Mental retardation/developmental delay	Diabetes
Asthma, Emphysema	🗌 Anemia
Cystic Fibrosis	High cho
Sickle cell disease or trait	Constinat

Cancer (list type)

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

C. Social History:

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

Name	Age	Relationship to patient	Any health	2. Are the parent(s): Single Married
Traine	Age	Relationship to patient	problems	Separated Divorced
				Remarried
				3. School History:
				A) Grade in school:
				B) Performance/Grades
				C) Recent change in behavior/performance?
4. Any unusual stre	esses at ho	ome 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

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

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

- Gallstones/ gall bladder problem Gastritis/ulcer Colitis, Crohns disease Celiac disease Liver problems Blood in stool
 - Irritable bowel syndrome
- **—** . . .
- Diabetes
 Anemia
 High cholesterol Constipation Polyps
- High blood pressure
 Heart disease or stroke

Dental problems	Other hormone/gland 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 Liver problems/jaundice/hepatitis	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
E. Feeding History:		
1. How was your child fed as an infant?	Breast-fed Bottle-fed	
a) If breast-fed, for how long?		
b) What formula did (does) your child	l receive?	
2. Is your child on a special or restricted diet	t? 🗌 Yes 🗌 No	
a) If yes, please describe:		
 Is your child's appetite normal or decreas 	ed?	
F. Stooling history:		
Did your child pass meconium (stool) while	in the nursery in the first 24-48 hours of life	e? \Box Yes \Box No
Did your child have normal stooling as a bal	oy?	🗌 Yes 📃 No
How often does your child stool now?		
When was your child's last bowel movement	nt?	
Does your child have accidents (so		🗌 Yes 🗌 No
•	• ·	
Is your child's stool malodorous (si	,	Yes No
What is the consistency of your chi		Soft Loose Watery
What is the color of your child's sto	ool? 🗌 Brown 🗌 Yellow 🗌 Green	Orange Red Black
Х		
Parent/Patient Signature	Ι	Date

Х

Physician Signature

Date

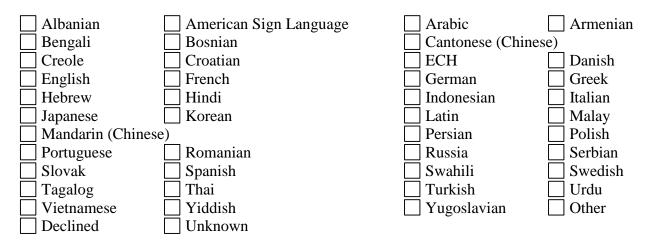
Race and Ethnicity Information

We want to make sure that all our patients get the best care possible. We would like you to tell us your child's racial and ethnic background as well as your preferred language so that we can review the treatment that all patients receive and make sure that everyone gets the highest quality of care. You may decline to answer if you wish.

The only people who see this information are registration staff, administrators for the practice, your care providers, and the people involved in quality improvement and oversight, and the confidentiality of what you say is protected by law.

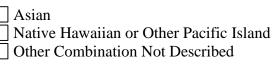
Please mark the appropriate response:

Primary Language



Race

- American Indian or Alaska Native Black or African American White
 - Declined



Ethnicity

- Hispanic or Latino or Spanish Origin
- Not Hispanic or Latino or Spanish Origin
- Declined

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.

New

Date:

Patient Name:

NYH #:

PRIMARY

Pharmacy Name:

Address:

Phone Number:

Fax Number:

SECONDARY (if applicable)

Pharmacy Name:

Address:

Phone Number:

Fax Number: