Pediatric Gastroenterology & Nutrition

NewYork-Presbyterian
Phyllis and David Komansky Center for Children's Health
Weill Cornell Medical Center

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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/1st 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

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.

- ☐ 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:

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

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

☐ 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 receive?
2. Is your child on a special or restricted diet? ☐ Yes ☐ No
   a) If yes, please describe:
3. Is your child's appetite normal or decreased?

F. Stooling history:

Did your child pass meconium (stool) while in the nursery in the first 24-48 hours of life? ☐ Yes ☐ No

Did your child have normal stooling as a baby? ☐ Yes ☐ No

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**

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

- ☐ Albanian
- ☐ American Sign Language
- ☐ Arabic
- ☐ Armenian
- ☐ Bengali
- ☐ Bosnian
- ☐ Cantonese (Chinese)
- ☐ Creole
- ☐ Croatian
- ☐ ECH
- ☐ Danish
- ☐ English
- ☐ French
- ☐ German
- ☐ Greek
- ☐ Hebrew
- ☐ Hindi
- ☐ Indonesian
- ☐ Italian
- ☐ Japanese
- ☐ Korean
- ☐ Latin
- ☐ Malay
- ☐ Mandarin (Chinese)
- ☐ Persian
- ☐ Polish
- ☐ Portuguese
- ☐ Romanian
- ☐ Russia
- ☐ Serbian
- ☐ Slovak
- ☐ Spanish
- ☐ Swahili
- ☐ Swedish
- ☐ Tagalog
- ☐ Thai
- ☐ Turkish
- ☐ Urdu
- ☐ Vietnamese
- ☐ Yiddish
- ☐ Yugoslavian
- ☐ Other
- ☐ Declined
- ☐ Unknown

Race

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Island
- ☐ White
- ☐ Other Combination Not Described
- ☐ 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:
