Pediatric Specialists of Texas | New Patient Gastroenterology (GI) History Questionnaire

Date:_____

Patient Name:_____ ☐ **M / F** **Date of Birth**:_____

Age:_____ **Nickname**:_____ **Hobbies**:_____

What is your relationship to the patient?_____

Reason for this visit, nature of complaint and when it started: _____

_____

What symptoms is the child experiencing?_____

What concerns you the most?_____

_____

Any known allergies (medicine or food)?_____

CURRENT OR PAST HISTORY: Please mark with an X if your child has or had problems with any of the following:

Ears		Lungs		Nervous System		Poor Appetite	
Eyes		Heart		Endocrine		Easy Tiring	
Nose		Blood		Infections		Trouble Sleeping	
Throat		Kidneys		Weight Loss		Menstrual Problems	
Teeth		Muscles		Poor Growth		Allergies	
Neck		Bones		Obesity			

What medications is your child currently taking? _____

_____

_____

Has your child had any surgeries? ☐ **Yes or** ☐ **No** **If yes, what kind of surgery has your child had**?

_____

What school does your child go to?_____

What grade?_____**Does your child have problems at school**?_____

Does your child have problems at home or with friends?_____

Child lives with: Both parents_____ Mother_____ Father_____

Step-parent_____ Foster parents_____ Grandparents_____ Other relatives_____

Is child adopted? ☐ Yes or No ☐

Current diet or formula:_____ **Breast Fed**? ☐ Yes or No ☐

Please mark an X if there is any family history of the following:

Cancer		Diabetes		Heart Disease		Liver Disease	
Ulcers		Colitis		Kidney Disease		Crohn's	
High Blood Pressure				Cystic Fibrosis		Other	

What diet does the child take?_____

_____Regular _____Gluten Free _____Low Fat

_____***Special Formula*** _____Other (Specify)_____

Please list name of formula_____

How many ounces or millilitres (ml) taken?_____

How often is it taken? _____

Formula is taken: _____by Mouth _____by G-Tube _____by NG Tube

How is his/her appetite? _____Good _____Fair _____Poor

How often does the child have a bowel movement?

_____Times per day or _____Times per week

Stools are: _____Normal _____Mushy _____Hard or Constipated _____Watery

Is there any blood visible in the stool? _____Yes _____No

Which lab is preferred by your insurance?_____

Has the child had any labs, X-rays or procedures ordered by our office since last visit?

Yes _____ No_____

If yes, where were they done? _____Methodist Hospital _____NC Baptist Hospital

_____Lab Corp _____Quest _____CPL _____Other (specify) _____

Did you bring any reports or results of labs or studies that were ordered by other physicians?

Yes_____ No_____(Please give to receptionist to make a copy)

Please list all medications the child is currently taking. Please include dosage and frequency.

	Name of Medicine	Dosage/Frequency
1.		
2.		
3.		
4.		

(For children over 13 years old) Does this child smoke? _____Yes _____ No

Office Use Only

Ht_____**Wt**_____**Temp**_____**Pulse**_____**Resp**_____**BP**_____