Pediatric Gastroenterology of Central Florida

Patient's Name_____ DOB: _____
Today's Date _____
Mother's name _____ Age_____
Mother's Occupation _____
Father's name _____ Age_____
Father's Occupation _____

PREGNANCY AND BIRTH

1. Did mother have any illness during pregnancy? _____
2. Was baby on time? No Yes Weeks of pregnancy: _____
   What was the BirthWeight? _____
3. Did the baby have any problems while in the hospital? _____
4. Was first bowel movement after birth passed normally? _____

PAST MEDICAL HISTORY

1. Any hospitalizations other than for birth? _____
2. Any diagnosed medical problems? _____
3. Any surgeries? _____
4. Any allergic reactions to medications, food, insect bites? _____
5. Any serious injuries? _____
6. Any medications taken regularly? _____

REVIEW OF SYSTEMS

Please circle any problems present currently for the **patient.** Please mark if patient is negative or positive for below symptoms

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☐ ☐ 1. **General**: Fever, Loss of appetite, Lethargy, Fatigue, Excess hiccups, Fussiness, Arching
☐ ☐ 2. **Eyes, Ears**: Runny eyes, Eye discharge, Pink eye, Jaundice, Ear pain
☐ ☐ 3. **Nose, Throat** : Runny Nose, Nosebleed, Sore throat, Throat pain, Hoarseness, Swallowing difficulty, Sores in mouth
☐ ☐ 4. **Cardiac**: Palpitations, Dizziness, Fainting, Heart murmur, Shortness of breath
☐ ☐ 5. **Respiratory** : Cough, Wheezing, Difficulty breathing, Chest pain, Asthma
☐ ☐ 6. **GI**: Nausea, Vomiting, Excess spitting, Heartburn, Fullness, Bloating, Abdominal pain, Diarrhea, Anal pain, Constipation, Bloody stools, Urgent stools, Stool accidents, Excess gas, Incomplete evacuation
☐ ☐ 7. **Neurological** : Headaches, Seizures, Muscle weakness, Developmental delay, Speech delay, Apnea, Tics
☐ ☐ 8. **GU/ GYN** : Urinary pain, Frequent urination, Blood in urine, Urine accidents, Vaginal discharge, Irregular menses
☐ ☐ 9. **Musculoskeletal** : Joint pains, Joint swelling, Muscle pains
☐ ☐ 10. **Skin** : Rash, Hives, Itching, Eczema, Excess Bruising
☐ ☐ 11. **Hematology** : Anemia, Bleeding tendency
☐ ☐ 12. **Psych** : ADHD, Anxiety, Depression, Bipolar disorder, Autism
☐ ☐ 13. **Endocrine** : Short stature, Hypothyroidism, High cholesterol, Excess weight gain, Weight loss
☐ ☐ 14. **Allergy/Immunology** : Frequent Infections, Immune Problems, Swollen lymph nodes, Recurrent sinus disease

FAMILY HISTORY

Does anyone in the **family** have any of the following medical problems? If Yes, please **circle** diagnosis and explain below.

Reflux Disease/Ulcer disease No/Yes Explain(If Yes) _____
Gall Bladder Disease No/Yes Explain(If Yes) _____
Lactose intolerance No/Yes Explain(If Yes) _____
Colitis (Ulcerative) No/Yes Explain(If Yes) _____
Crohn's Disease No/Yes Explain(If Yes) _____
Spastic Colon/ IBS No /Yes Explain(If Yes) _____
Colonic polyps/ Colon cancer No/Yes Explain(If Yes) _____
Other medical problems: _____

SOCIAL HISTORY

1. Where do you **live**? (Check one) Pvt house: ____ Apt: ____ Mobile home: ____Other_____
2. Are there any **smokers** in the household? No/ Yes (if Yes, whom? Indoors/Outdoors)_____
3. Do you have **pets** in your home? No / Yes _____
4. Who lives with the patient? _____
5. What **grade** is the child in? _____ Private/ Public school? Special Ed? No/Yes **Daycare**? No/Yes
6. Do you have city or well **water**? (Check one) City: ___Well: ___
7. Recent/Pertinent **Travel**? No/Yes _____
8. **Sexually active**? No/Yes_____ 9. **Drug/Alcohol/Tobacco use**? No/Yes_____

INTAKE HISTORY