Center for Pediatric Digestive Health and Nutrition
at Arnold Palmer Hospital for Children

Please complete this questionnaire. It will be an important part of your child's medical record.

Patient Name: ______________________ Date: ______________________
DOB: __________ Age: ______________ MR #: ______________________
Primary Doctor: ______________________ Tel. #: ______________________

Reason for Visit: ____

A. Past Medical History

1. Birth History: Birth Weight: ________ Length: ______ Full Term / Premature (circle one)

Pregnancy problems: ____

____

Labor/Delivery: Vaginal / C-section (circle one) Describe any problems:

____

Problems in the Nursery/ 1st month of life: ______________________

____

2. List any medical problems that your child has.

____

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

____

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

____

Drug Allergies: ______________________

Are immunizations up to date?
☐ Yes ☐ No

4. 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.

☐ Celiac Disease
☐ Colon Cancer
☐ Constipation
☐ Crohns Disease
☐ Cystic Fibrosis
☐ Gastroesophageal Reflux
☐ Gastrointestinal Disorder
☐ Irritable Bowel Syndrome
☐ Liver & Gallbladder Disease
☐ Polyps
☐ Ulcerative Colitis
☐ Ulcers
☐ Allergic Disease
☐ Anesthesia Problems
☐ Bleeding Problems
☐ Blood Disorders
☐ Diabetes
☐ Headaches
☐ Heart Disease
☐ Hypertension
☐ Infant/Child Death
☐ Kidney Disease
☐ Lipids /High Cholesterol
☐ Lung Problems
☐ SIDS

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

3. Exposures: Travel ______ Camping ______ Pets ______ Snakes ______ Lizards ______ Turtles ______

4. Sick Contacts: ________ Water Source: City ________ or Well ________

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. ________

____

5. Who smokes in the family? ______________________

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

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 period ended _______

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
☐ Liver problems/jaundice/hepatitis

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

Eyes
☐ Wear glasses
☐ Blurry vision
☐ Double vision
☐ Eye pain

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

E. Feeding History:

How was your child fed as an infant? ☐ Breast-fed ☐ Bottle-fed
If breast-fed, for how long? ____
What formula did(does) your child receive? ______________________________
Is your child on a special or restricted diet? ☐ Yes ☐ No
If yes, please describe: ____
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? ___________________________________
Does your child have accidents (soils underpants)? ☐ Yes ☐ No
What is the consistency of your child's stool? ☐ Hard ☐ Soft ☐ Loose ☐ Watery
Is your child's stool malodorous (smells awful)? ☐ Yes ☐ No
What is the color of your child's stool? ☐ Brown ☐ Yellow ☐ Green ☐ Orange ☐ Red ☐ Black