NEW GI PATIENT HISTORY

Patient Name: ____ **Date of birth:** ______________
Person completing form: ________________________________ **Relation:** _______________
Who referred you to our clinic? Primary Care Provider Self referral Other ___________
Is this a second opinion? NO YES
Primary Care Provider: ____
Preferred pharmacy & location: ____

REASON FOR G.I. VISIT: ____

SOCIAL HISTORY: Grade in school: ____________ With whom does patient live? ____________________

BIRTH HISTORY:
Birth weight: ______lb ______oz Gestation Age: How many weeks? _______ Full term Premature
Delivery: Vaginal C-section Complications? No Yes __________________________
Medical problems for baby after delivery? No Ye s ____

DEVELOPMENTAL:
At what age did your child? Roll over __________ Walk__________ Toilet train__________ Unknown

IMMUNIZATIONS: Is patient up to date? No Yes

SURGERIES: No Yes If yes, list the type and date.

HOSPITALIZATIONS: No Yes If yes, list the type and date.

MEDICATIONS/SUPPLEMENTS: No Yes If yes, list the name and dose.

REVIEW OF SYSTEMS: Does your child have any of the following now or in the past?

Constitutional **No Yes**
Growth problems
Unusual weight loss
Repeated unexplained fevers
Allergies
Seasonal allergies
Food allergies
If yes, please list ______________
Blood/Circulation
Anemia
Bleeding tendencies
Sickle cell trait/disease
Cardiovascular
Heart Problems
If yes, explain _____________
Dermatology
Skin rashes
If yes, explain ______________
Endocrine
Diabetes
Growth problems
Menstrual periods
LMP __________
Ears, Nose & Throat
Hearing loss
Recurrent ear/sinus infections
Snoring
Eye
Vision problems

GI **No Yes**
Constipation
Diarrhea
Vomiting
Stomach pain
Kidney/urinary problems
Urine infections
Musculoskeletal
Joint problems
Headaches
Cerebral palsy
Seizures
Hydrocephalus
Respiratory
Pneumonia
Asthma/Reactive airway
Persistent cough
Psychological problems
Learning disorders
ADHD
Other___________________

Signature ________________________________

Date ________________________________