

*Office Use Only*WT: \_\_\_\_\_\_kg \_\_\_\_\_\_ lb

HT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Temp: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Resp: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pulse: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Oxygen: \_\_\_\_\_\_\_\_\_\_\_\_\_

BP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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VFC: [ ] V02 -- MDD

[ ] V03 -- No Ins

[ ] V04 -- Native

[ ] V07 -- AVAP

INSURANCE:

Copay / Co-ins

Statement Balance

**GI Symptoms**

**Is this a follow-up appointment? Yes / No.**

**Child’s name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Child’s birthday:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Who is your child’s primary care physician? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What is your concern today regarding your child?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Symptoms**

|  |
| --- |
| ***For Girls Only if Applicable***  Last menstrual period was: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Periods started at age:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Any problems?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* |

Abdominal pain yes/no. If yes, how long? \_\_\_\_\_\_\_

Constipation yes/no. If yes, how long? \_\_\_\_\_\_\_

Hard stools? yes/no.

Stool “accidents”? yes/no

Blood in stool? yes/no. If yes, how long?\_\_\_\_\_\_\_

Stooling frequency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How much water does your child drink daily? \_\_\_\_\_\_\_\_\_\_\_\_

Is your child a picky eater? Yes/no.

**Review of systems**:

Fever yes/no. If yes, how long? \_\_\_\_\_\_

Decreased appetite yes/no. If yes, how long? \_\_\_\_\_\_

Heartburn yes/no. If yes, how long? \_\_\_\_\_\_

Vomiting yes/no. If yes, how long? \_\_\_\_\_\_

Diarrhea yes/no. If yes, how long? \_\_\_\_\_\_

Urinary symptoms yes/no. If yes, how long? \_\_\_\_\_\_

Dry skin yes/no. If yes, how long? \_\_\_\_\_\_

Rash yes/no. If yes, how long? \_\_\_\_\_\_

Joint pain yes/no. If yes, how long? \_\_\_\_\_\_

Sleep problems yes/no. If yes, how long? \_\_\_\_\_\_

Does your child have a medication allergy? Yes/no. What medication/reaction? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child have any chronic medical problems? Yes/no. If yes, please explain. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child been admitted to the hospital overnight? Yes/no. If yes, please explain. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child had any surgeries? Yes/no. If yes, please explain. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your child taking any daily prescribed medications? Yes/no. If yes, please explain. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your child taking any over-the-counter cold medications? Yes/No. If yes, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Motrin or Tylenol? Yes/No

Does anyone in the family have:

Esophageal reflux/peptic ulcer disease ? Yes/no please circle: father/mother/sibling/grandparent

Crohn’s disease or ulcerative colitis? Yes/no please circle: father/mother/sibling/grandparent

Malignancy of the gastrointestinal tract? Yes/no please circle: father/mother/sibling/grandparent

Does anyone in the household smoke (inside or outside)? Yes / No. If yes, who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any pets? Yes / No. Which kind/how many? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child attend daycare/school? (please circle) Where do they attend/what grade in school? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are your child’s immunizations up-to-date? Yes/no. If no, please explain. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child used the following “over the counter” or prescribed treatments for constipation: (please circle)

Enemas, glycerin or other suppositories, lactulose, mineral oil, Miralax, other

**This form completed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**