

Office Use Only

VFC: [] V02 -- MDD
 [] V03 -- No Ins
 [] V04 -- Native
 [] V07 -- AVAP

INSURANCE:
 Copay / Co-ins _____

Statement Balance _____



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WT: _____ kg _____ lb

HT: _____

Temp: _____

Resp: _____

Pulse: _____

Oxygen: _____

BP: _____

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

- 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.

For Girls Only if Applicable

Last menstrual period was: _____

Periods started at age: _____

Any problems? _____

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 _____