New GI/ Liver Patient Questionnaire

Patient's Name: _____ Date of Birth: _____

Patient's Primary Care Doctor: _____

Why are you at the GI or Liver Clinic today? _____

Is this concern a new or recurrent problem? _____

Past History:

Is your child taking any medications, including any over-the counter medications? □ Yes □ No
Please list the medications:

Medication	Dosage	Medication	Dosage

Does your child have any long-term chronic problems? □ Yes □ No
If so, what are the problems?

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Has your child ever had any surgeries, problems with anesthesia, or admissions to the hospital? □ Yes □ No
If so, please tell us when, what and where:

Dates	Type of Surgery/ Reason for Admission	Hospital and Location

Has your child had any serious illnesses or documented allergies (medicines, food or environmental)?
□ Yes □ No
If so, please list them: _____

_____

Are your child's immunizations up to date? □ Yes □ No
If not, please list the immunizations: _____

_____

Has the growth of your child (height and weight) been normal? □ Yes □ No

Family History: Father's Height: _____ Mother's Height: _____

	Relationship to the Patient						
Condition/ Illness	**None**	**Mother**	**Father**	**Brother**	**Sister**	**Grandparent**	**Other**
Heart Disease							
Diabetes							
High Blood Pressure							
Liver Disease							
High Cholesterol							
Alcohol/ Drug Abuse							

Patient Name: _____ MR# _____

Condition/ Illness	None	Mother	Father	Brother	Sister	Grandparent	Other
GER (Reflux)							
Mental Illness							
Seizures							
Colon/ Rectal Cancer							
Colon Polyps							
Crohn's Disease							
Ulcerative Colitis							
Gall Bladder Disease							
Constipation							
Ulcers							
Anemia							
Bleeding Problems							
Irritable Bowel Syndrome							
Breathing Problems							
Other							

Social History:

Who does the child live with? (Check all that apply) □ Mother □ Father □ Grandparent(s) □ Other

What type of water do they drink? □ Well □ City Is your child exposed to smoke? □ Yes □ No

Do you have pets? □ Yes □ No If so, what kind? _____

Does your child attend: □ Daycare □ School; What grade?_____

Do the symptoms cause school absences? □ Yes □ No

Does your child exercise? □ Yes □ No What type? _____ How often? _____

Other activities for school aged children (i.e. sports or work): _____

_____

Diet History:

Please describe a typical daily diet (with approximate amounts):

- Breakfast: _____
- Lunch: _____
- Dinner: _____
- Snacks: _____

What type of liquids does your child drink?

□ Milk ____ oz Please check all that apply: □ Whole □ 2% □ 1% □ Fat Free □ Soy □ Other
□ Formula ____ oz What Kind: _____
□ Water _____ oz □ Soda ____ cans □ Juice ____ oz □ Tea/ Coffee ____ oz

Patient Name: _____ MR# _____

Birth Information:

Was your child born full term? □ Yes □ No If no, how many weeks premature? _____

Birth Length: _____ Birth Weight: _____

Were there any complications during the pregnancy? □ Yes □ No
If yes, please explain: _____

Did your child stay in the Special Care Nursery (NICU) for any reason? □ Yes □ No
If yes, please explain: _____

Developmental History:

Has your child met his/ her developmental milestones on time (i.e., for infants: rolling- over, sitting alone, walking)?
□ Yes □ No

If no, please explain: _____

_____

Review of Systems:

General	Yes	No	If yes, please explain and give the date symptoms first started
Fever or Chills			
Sweats			
Weight Change			
Vision Changes			
Eyes, Ears Nose, Throat			
Nose Bleeds			
Problems Swallowing			
Lesions in Mouth			
Sore Throat			
Eye Pain			
Hoarseness			
Yellow Eyes			
Cardiovascular			
Heart Murmur			
Fast Heart Beat			
Chest Pain			
High Blood Pressure			
Heart Skipping Beats			
Respiratory			
Wheezing			
Shortness of Breath			
Cough			
Asthma			
Choking			
Cyanosis			
Gastrointestinal			
Abdominal pain			
Constipation			
Diarrhea			
Nausea or Vomiting			
Reflux (Heartburn)			

Patient Name: _____ MR# _____

Gastrointestinal Cont.	Yes	No	If yes, please explain and give the date symptoms first started
Bloody Stools			
Painful Bowel Movements			
Excessive Gas			
Loss of Appetite			
Black Stools			
Large Liver or Spleen			
Genitourinary			
Burning with urination			
Blood in urine			
Recurrent Infections			
Musculoskeletal			
Swelling			
Joint or Back Pain			
Arthritis			
Disuse of Arms or Legs			
Skin			
Sores			
Eczema			
Jaundice (Yellow Skin)			
Rashes			
Endocrine			
Cold Intolerance			
Diabetes			
Thyroid Abnormalities			
Hematology			
Bleeding Easily			
Bruising Easily			
Blood Disorder			
Neurological			
Memory Changes			
Dizziness/ Fainting			
Blurred Vision			
Numbness/ Tingling			
Headache			
Seizures			
Psychological			
Anxiety			
Depression			
Other			
Other			

Any Other Concerns? _____

_____

_____

Office Use Only:

MR#: _____ Physician Reviewed By: _____ Date: _____