PEDIATRIC GASTROENTEROLOGY ASSOCIATES

Consultation Questionnaire

Today's Date: _____

What are we seeing you for today?

_____

_____

Patient Information:

Patient's Name: _____ Date of Birth: _____ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Alternate Phone: _____

Gender: ☐ Male ☐ Female

Race: ☐ Caucasian ☐ Hispanic ☐ African American

Ethnicity: ☐ Non-Hispanic ☐ Hispanic

What Language is spoken primarily in your home? ☐ English ☐ Spanish ☐ Other_____

Mother's Information:

Name: _____ Date of Birth: _____ SSN: _____-_____-_____

☐ Please check box if your address is same as your child's.

Address/Phone (If different than child): _____

Father's Information:

Name: _____ Date of Birth: _____ SSN: _____-_____-_____

☐ Please check box if your address is same as your child's.

Address/Phone (If different than child): _____

Insurance Guarantor:

Relationship to patient: _____

Employer: _____ Work Phone: _____

Primary Insurance:

_____

Secondary Insurance: (If applicable) _____

Medications:

Is your child on **any** medications? ☐Yes ☐ No

Please list any medications that your child is taking (**please include the dosage**):

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

Past Medical History:

- **Birth History**:
  Birth Weight: _____ (lbs) _____ (oz)
  Was the baby carried to full term? ☐Yes ☐ No

	YES	NO
Were there any problems with pregnancy?	☐	☐
Explain_____		
Were there any problems during labor?	☐	☐
Explain_____		
Were there any problems in the nursery?	☐	☐
Explain_____		
Jaundice?	☐	☐
Explain_____		
Constipation?	☐	☐
Explain_____		

- **Feeding History**:
  What was your child first fed as a newborn? ☐ Breast milk ☐ Formula
  When were solids introduced?
  _____
- **Diet**: Would you say their diet is normal for his/her age? ☐Yes ☐ No

  How would you describe his/her current diet?
  _____

Are there any foods restricted from the diet?

_____

- **Growth & Development**:
  Has your child's growth and development been normal? ☐Yes ☐ No
  Has your child achieved growth milestones on time? ☐Yes ☐ No

- **Are immunizations up to date**? ☐Yes ☐ No

Allergies:

Does your child have any allergies? ☐Yes ☐No

Please list any allergies that your child may have:

_____

_____

_____

_____

Past Surgical History:

Has your child had any surgeries? ☐Yes ☐No

Please list any surgeries:

_____

_____

_____

_____

_____

Past Hospitalization History:

Has your child ever been hospitalized? ☐Yes ☐No

Please list any hospitalizations and reason for admission:

Hospitalizations	Reason for Admission

_____

_____

Has your child had any serious problems with:

	YES	NO	EXPLAIN
His/her eyes, ears, nose or throat?	____	____	_____
Breathing (pneumonia, asthma, etc.)?	____	____	_____
His/her heart blood pressure?	____	____	_____
Kidney or bladder infection?	____	____	_____
Joint, bones, or muscles?	____	____	_____
Seizures?	____	____	_____

Family History:
Has anyone in the family suffered from:

	YES	NO	LIST RELATIVE
Food allergies	_____	_____	_____
Asthma	_____	_____	_____
Bleeding disease	_____	_____	_____
Cystic Fibrosis	_____	_____	_____
Chronic Diarrhea	_____	_____	_____
Constipation	_____	_____	_____
Crohn's Disease	_____	_____	_____
Ulcerative Colitis	_____	_____	_____
Ulcers	_____	_____	_____
Jaundice	_____	_____	_____
Hepatitis	_____	_____	_____
Liver Disease	_____	_____	_____
Cirrhosis of Liver	_____	_____	_____
Gallstones	_____	_____	_____
Chronic Abdominal Pain	_____	_____	_____
Polyps	_____	_____	_____

Social History:
Parental Involvement in child care: Father: Yes/No Mother: Yes/No
Tobacco Exposure: Is your child exposed to tobacco products at home? YES NO

Who uses the tobacco products?

_____

What products are used? ☐ Cigarettes/cigars/pipes ☐ Chewing Tobacco

Parent's Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Living Situation: ☐ Living together ☐ Separated

Who Lives at home with your child?

_____

_____

Travel: Has your family or child traveled outside of the country in the past 6 months?

YES NO

Animals: Are there pets in the household? YES NO

☐ Dog ☐ Cat ☐ Bird ☐ Other _____

Sick Contact: Has your child need exposed to someone who is/has been sick?

YES NO

Alcohol: Does anyone in the household consume alcohol?

YES NO

Drug Use: Does anyone in the household use any other substances?

YES NO

If yes, what type? _____

What type of water does your house have? CITY WELL

School age children:

How is his/her attendance? ☐ Excellent ☐ Good ☐Fair ☐ Poor

How is his/her school performance? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

School Concerns? ☐ No ☐Yes, _____

Pharmacy Information:

Pharmacy Name: _____

Address: _____ Telephone: _____

To what you would like us to send a report of our evaluation?

Doctor's Name: _____ **Telephone**: _____

Address:_____

Is there any information you would like us to know?

_____

Do we have your permission to take a photo of your child for our medical records?

Allow ☐ Decline ☐

How would you like to be contacted for Appointment confirmation?

Phone call ☐

Text Message ☐

Telephone Number to call/text: _____

Signature _____ ***Date***: _____