Banner Health®

NEW PATIENT MEDICAL HISTORY
PEDIATRIC GASTROENTEROLOGY

Patient Name: _____ **Date of Birth:** _____ **Gender: M / F**

Person filling out form and relationship to patient: _____

Please provide as much detail as you are able so that we can give you the safest and best care possible.

Preferred Pharmacy (name and location): _____

How did you hear about us? _____

Primary Care Provider

Name: _____ Phone #: _____

Address: _____ Fax #: _____

Reason for visit: _____

Duration of symptoms: _____

Has your child been evaluated by another GI doctor? ❑ Yes ❑ No If yes, name: _____

What tests have been performed: Lab ❑ Yes ❑ No Radiology: ❑ Yes ❑ No Any other testing: _____

Has your child seen any other specialists: _____

ALLERGIES

❑ **No known allergies** List any allergies and intolerances to **medications, food or the environment.**

Allergy:	**Reaction:**

MEDICATIONS

❑ **No Medications** List any medications you are taking, with dose and how often.

Medication Name:	**Dose:**	**How often?**	**Date Started**

List any Vitamins, Supplements and Over the Counter Medicines

1.	**4.**
2.	**5.**
3.	**6.**

PATIENT MEDICAL HISTORY

List any current or past medical conditions (please place checkmark by any current problems).

❑ _____ ❑ _____

❑ _____ ❑ _____

❑ _____ ❑ _____

DO NOT RETAIN AS PART OF THE PERMANENT MEDICAL RECORD

9999-0124
(01/2017)

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SURGERIES AND/OR HOSPITALIZATIONS

Has your child had any surgeries or been hospitalized? (provide dates and reason below)

Date:	Reason:	Date:	Reason:

FAMILY HISTORY

List health conditions for each family member.

	Alive	Deceased	Age of Death	Health Condition(s)
Father				
Mother				
Paternal Grandmother				
Paternal Grandfather				
Maternal Grandmother				
Maternal Grandfather				
Brother				
Sister				

SOCIAL HISTORY

Patient lives with: ❑ Mother ❑ Father ❑ Siblings ❑ Grandparents ❑ Step-Parents ❑ Foster Parents ❑ Adoptive Parents

Child attends school: _____ Grade: _____ Not applicable _____

Extracurricular activities/sports: _____

Father's occupation: _____

Mother's occupation: _____

BIRTH HISTORY

(Complete of under 5 years old)

Patient Adopted _____ If yes, Birth Country: _____

Birth Weight: _____ lbs. _____ oz. Length: _____ Head Circumference: _____ inches Time of Birth: _____

Type of delivery: ❑ Normal Vaginal ❑ C-Section ❑ Repeat C-Section ❑ Emergent C-Section (Reason) _____

Complications during pregnancy/delivery: _____

Gestational age: _____

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REVIEW OF SYSTEMS

CONSTITUTIONAL			GASTROINTESTINAL			IMMUNOLOGICAL		
Chills	Yes	No	Abdominal pain	Yes	No	Allergic rhinitis	Yes	No
Decreased activity	Yes	No	Bloody Stool	Yes	No	Environmental allergies	Yes	No
Decreased appetite	Yes	No	Constipation	Yes	No	Food allergies	Yes	No
Fatigue	Yes	No	Diarrhea	Yes	No	Hives	Yes	No
Fever	Yes	No	Feeding issues	Yes	No	**HEMATOLOGIC**		
Fussiness	Yes	No	Heartburn	Yes	No	Easy bleeding	Yes	No
Irritability	Yes	No	Liver issues	Yes	No	Easy to bruise	Yes	No
Lethargy	Yes	No	Reflux	Yes	No	Swollen lymph nodes	Yes	No
Weight gain	Yes	No	Vomiting	Yes	No	Red or purple spots	Yes	No
Weight loss	Yes	No	Vomiting blood	Yes	No	**SKIN**		
HEENT			**ENDOCRINE**			Acne	Yes	No
Difficulty swallowing	Yes	No	Excessive thirst	Yes	No	Eczema	Yes	No
Earaches/Drainage	Yes	No	Excessive output	Yes	No	Itching	Yes	No
Eye redness	Yes	No	**NEUROLOGICAL**			**PSYCHIATRIC**		
Hearing loss	Yes	No	Dizzy/light headed	Yes	No	Behavioral changes	Yes	No
Nasal congestion	Yes	No	Frequent or recurring headaches	Yes	No	Depression	Yes	No
Pharyngitis	Yes	No	Seizures	Yes	No	Difficulty concentrating	Yes	No
RESPIRATORY			**GENITOURINARY**			Distorted body image	Yes	No
Cough	Yes	No	Decrease in urine output	Yes	No	Learning issues	Yes	No
Known TB exposure	Yes	No	Painful urination	Yes	No	Self-conscious	Yes	No
Shortness of breath	Yes	No	Enuresis	Yes	No			
Wheezing	Yes	No	Flank pain	Yes	No			
CARDIOVASCULAR			Foul urine odor	Yes	No			
Chest pain	Yes	No	Blood in urine	Yes	No			
Fainting	Yes	No						
Irregular heart beat	Yes	No						
Murmur	Yes	No						

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