Minnesota Gastroenterology, P.A.

Pediatric Patient History Form

Please complete and bring to appointment

Dear Patient/Parent/Guardian: Thank you for taking the time to complete this form prior to your appointment. PLEASE PRINT and complete the form to the best of your ability. Spelling is NOT important. If you have trouble with any section, leave it blank, and the doctor can go over that area with you. If you need assistance with the entire form, inform the receptionist, and one of our staff persons will assist you.

NAME _____ **Date of Birth**_____**Age**: ____ **Date of Visit:** _____

Current Primary Care Physician and Clinic _____
Physician who referred you to us _____
Symptoms or reason for this visit _____
When did the problem first start? _____
How often does the problem occur? _____
Is there anything that gives relief (i.e., change in position, resting, etc?) _____
Have you had any test (blood work, x-rays, etc.) pertaining to the reason for this visit? ____yes _____no
If so, when and where were they done? _____

CIRCLE ANY GI SYMPTOMS YOUR CHILD MAY HAVE:

Difficulty or painful swallowing	Loss of appetite	Heartburn
Gas/bloating	Weight loss	Diarrhea
Vomiting/Nausea	Pain in abdomen	Constipation
Black or red stools	Chalky colored stools	Jaundice (yellow skin/eyes)

PERSONAL HEALTH HISTORY

Surgeries: Type of operation and when

_____
_____
_____
_____
_____

Medical History: Major or Chronic illness & Date of Onset

_____
_____
_____
_____
_____

BIRTH HISTORY (Children 3 & under)
Weeks at birth/Birth weight _____
Any complications _____

FAMILY HEALTH HISTORY

(Enter which family member & their relationship to your child. If family member is deceased, at what age did he/she die?)

Colon or rectal cancer _____
Colon polyps _____
Crohn's disease _____
Ulcerative Colitis _____
Stomach ulcers _____
Celiac Disease _____
Liver/Gallbladder disease _____
Other _____

SOCIAL HISTORY

Parent occupation: Mother: _____ Father: _____

Who lives in home with patient? _____

Grade in school: _____ Activities _____

Missing school? _____yes _____no Smoking in home? _____ Patient? _____

Patient's Alcohol use: _____ Patient's Recreational drug use: _____

DIET/NUTRITION

Type of diet currently? _____

Special diet _____yes _____no Type: _____

Gastrostomy tube: _____ Jejuenostomy tube: _____

If feeding tube in place, size and when placed and/or last changed: size_____ Date Placed/Changed _____

Type of formula: _____ Current feeding schedule: _____

Oral intake (please describe): _____

PLEASE CIRCLE IF THESE SYMPTOMS ARE PRESENT:

General	Fever or chills, sweats, fatigue, weakness, lack of energy, bleeding tendency, weight gain or loss
Eyes, ears, nose, throat	Eye or ear problems, hoarseness, sore throat, sinus problems, mouth sores
Skin	Rash, itching
Heart	Chest pain, heart murmur, dizziness, fainting, ankle or leg swelling
Lungs	Chronic cough, shortness of breath, asthma
Endocrine	Diabetes, thyroid disease
Genitourinary	Frequent urination, painful urination, urgent urination, blood in urine, brown urine
Joints	Back pain, arthritis, joint or muscle pains
Neurological-psychiatric	Severe headaches, poor sleep, sadness/depression, seizures, developmental
Allergy/Immune	Immune deficiency

Explain above if needed: _____

_____

_____

_____

_____ _____

(Patient/Parent/Legal Guardian Signature/Date) **(Reviewing Provider Signature/Date)**

Race/Ethnicity:

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or other Pacific Islander
- ☐ Latino or Hispanic
- ☐ White
- ☐ I do not wish to disclose

Allergies to medications? Yes/No _____ **Allergic to Latex?** Yes/No

Current Medications
(Including over-the-counter medicines such as aspirin, Tylenol, vitamins, herbs, supplements, etc.)

Name	Reason	Dose/How often
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Pharmacy Name/Location/Phone #: _____