The Children's Hospital of Philadelphia®

DIVISION OF GASTROENTEROLOGY, HEPATOLOGY & NUTRITION

34th St. and Civic Center Blvd, Philadelphia, PA 19104, phone 215-590-3630
www.chop.edu/gastroenterology

Please complete this form prior to your child's visit. Please fax to **(215) 590-7224** or e-mail it back to us at CHOPGIAccess@email.chop.edu before your child's appointment. Please bring the original form with you when you come for your first visit. This provides us with information about your child's health and past medical history.

Today's date: _____ GI appointment date: _____

Child's name: _____ Date of birth: _____ Sex: ☐ M ☐ F

Person completing this form: _____ Relationship to child: _____

Who referred you to us? _____

What other doctors does your child see?

Pediatrician Information

Name: _____ Telephone: _____

Address: _____

Other Specialists

Name & Specialty: _____

Address: _____

Telephone: _____

Name & Specialty: _____

Address: _____

Telephone: _____

Name & Specialty: _____

Address: _____

Telephone: _____

What are the concerns that bring your child to the GI doctor?

- ☐ abdominal pain
- ☐ vomiting
- ☐ reflux
- ☐ choking
- ☐ feeding difficulty
- ☐ other (specify)
- ☐ constipation
- ☐ blood in stool
- ☐ loose stool/diarrhea
- ☐ accidents with stool
- ☐ liver disease
- ☐ weight loss
- ☐ abnormal lab results
- ☐ jaundice
- ☐ poor growth

Does y our child have any known allergies?

Allergies	Name of Food or Medication	What was the reaction?
Drugs ☐ Yes ☐ No		
Latex	☐ Yes ☐ No	
X-ray dyes	☐ Yes ☐ No	
Blood products	☐ Yes ☐ No	
Foods ☐ Yes ☐ No		

Please tell us if your child has any of the following conditions listed below:

G6PD deficiency ☐ Yes ☐ No ☐ Don't know
Malignant hyperthermia ☐ Yes ☐ No ☐ Don't know
Ketogenic diet ☐ Yes ☐ No ☐ Don't know
Prolonged QT ☐ Yes ☐ No ☐ Don't know

Does your child need pre-medications or antibiotics before dental procedures or surgery?

☐ Don't know ☐ No ☐ Yes If yes, explain: _____

Please list your child's current medications (including over the counter medication, vitamins and supplements):

Medication	Dose/Strength	How often?	Directions for use
			☐ Oral ☐ Other
			☐ Oral ☐ Other
			☐ Oral ☐ Other
			☐ Oral ☐ Other
			☐ Oral ☐ Other
			☐ Oral ☐ Other
			☐ Oral ☐ Other
			☐ Oral ☐ Other
			☐ Oral ☐ Other

Pregnancy and Birth History (Answer only if your child is less than 8 years)

Were there any complications during pregnancy? ☐ Yes ☐ No
If yes, check the ones that apply:
☐ Gestational Diabetes
☐ Elevated blood pressure
☐ Pre-eclampsia
☐ Pre-term contractions
☐ Meconium aspiration
☐ Polyhydramnios (extra amniotic fluid)
☐ Other _____

How many weeks into pregnancy (Gestational age) was your baby delivered? : _____weeks

How was the baby delivered?
☐ vaginal
☐ vacuum/forceps assist
☐ Cesarean - If Cesarean, why? _____

Baby's Birth weight: _____lbs_____ oz Birth length: _____inches

Any complications with your baby at birth? ☐Yes ☐ No
If yes, check the ones that apply:
☐ Jaundice requiring phototherapy
☐ Other _____

Was your baby in the NICU? ☐ Yes ☐ No
If yes, why?
_____

If yes, how long was your baby in the NICU? _____

When did your baby have the first bowel movement (meconium)
☐ Before 48-72 hours old
☐ Greater than 72 hours
☐ Not sure

Did your baby ever drink formula? ☐ Yes ☐ No
If yes, what brand (s) of formula? _____

Immunization History of your child
Are your child's immunizations up to date? ☐ Yes☐ No
If no, why? _____

Has your child ever been admitted to a hospital (excluding ER visit)? ☐ No ☐ Yes If yes, please explain

When?	Which hospital?	Reason for Admission?	MD/CRNP notes

Please enter your child's past medical and past surgical history. If you answer yes, please explain symptoms or diagnosis in the box provided.

Please check the box that applies to your child	Past Medical History	Surgical History ☐ None	MD/CRNP notes
GI ☐ No ☐ Yes Please explain:			
ENT ☐ No ☐ Yes Please explain:			
Lungs ☐ No ☐ Yes Please explain:			
Heart ☐ No ☐ Yes Please explain:			
Nervous System ☐ No ☐ Yes Please explain:			
Endocrine ☐ No ☐ Yes Please explain:			
Urology ☐ No ☐ Yes Please explain::			
Psychology ☐ No ☐ Yes Please explain:			

Family/Social History

Who lives at home with the patient? _____

Names and ages of brothers and sisters? _____

Does your child go to?

- ☐ Day Care
- ☐ Medical Day Care
- ☐ Head Start
- ☐ School
  - ☐ Preschool
  - ☐ Kindergarten
  - ☐ Grade _____
- ☐ Other _____

How is your child's attendance at school?

Has your child's behavior or grades at school been affected? Please let us know how.

_____

Do you have any pets?

☐ No ☐ Yes If so, what kind?

Any recent travel outside of the tri state area?

Home water supply?
☐ Well ☐ City

Does anyone smoke around your child?
☐ No ☐ Yes

Does your child smoke?
☐ No ☐ Yes

Family ancestry/ethnic background (check all that apply):
☐ Asian/Pacific Islander
☐ Black/African American
☐ Hispanic/Latino
☐ Native American Indian
☐ White/Caucasian
☐ Other _____

Family Medical History

Dad's height: _____ft _____in Mom's height: _____ft _____in

Please check (√) the boxes that apply to your child and relatives.

	Abdominal pain	Allergy	Asthma	Celiac disease	Chronic diarrhea	Colon Cancer	Constipation	Crohn's disease/IBD	Cystic Fibrosis	Gastroesophageal reflux (GERD)	Hirschsprung's disease	Irritable Bowel Syndrome (IBS)	Migraine/Headaches	Pancreatitis	Polyps	Thyroid disease	Ulcers	Ulcerative colitis (IBD)	Liver disease	Gallstones	Jaundice	Hepatitis	Cirrhosis
Sister Name-	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Brother Name-	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Biological mother	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Biological father	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Maternal grandmother	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Maternal grandfather	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Paternal grandmother	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Paternal grandfather	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other (please specify)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Review of Systems

If there are symptoms, please complete by checking the box (s) or writing it in the spacing provided.

General ☐ Normal ☐ fever ☐ excessive sweating ☐ fatigue ☐ exercise intolerance ☐ excess weight gain ☐ weight loss, how much _____ ☐ poor appetite ☐ feeling full after eating a small amount ☐ other: _____	**Skin** ☐ Normal ☐ eczema ☐ dry skin ☐ acne ☐ bruising ☐ hair loss ☐ itching ☐ jaundice ☐ lumps/bumps ☐ other: _____	**Eyes:** ☐ Normal ☐ glasses ☐ contact lenses ☐ light sensitivity ☐ other: _____
Ears, Nose & Throat: ☐ Normal ☐ hearing Loss ☐ snoring ☐ ear infections ☐ sinus infections ☐ sleep apnea ☐ tonsillitis ☐ tooth decay ☐ mouth sores ☐ other: _____	**Respiratory:** ☐ Normal ☐ asthma/Wheezing ☐ pneumonia ☐ persistent Cough ☐ pneumonia (more than 1 or 2) ☐ other: _____	**Endocrine:** ☐ Normal ☐ diabetes ☐ adrenal problems ☐ hypothyroidism ☐ hyperthyroidism ☐ obesity ☐ menstrual periods (if applicable) Age when periods started: _____ cycles - ☐ regular ☐ irregular ☐ other: _____
Kidney: ☐ Normal ☐ kidney failure ☐ urinary tract infections ☐ bedwetting ☐ other: _____	**Immunology**: ☐ Normal ☐ other: _____	**Cardiovascular:** ☐ Normal ☐ heart problems ☐ heart surgery ☐ hypertension ☐ congenital heart disease ☐ other**:** _____
Blood circulation: ☐ Normal ☐ Anemia ☐ sickle cell disease ☐ sickle cell trait ☐ thalassemia trait ☐ bleeding tendency ☐ other: _____	**Musculoskeletal system**:☐ Normal ☐ bone problems ☐ back problems ☐ joint problems ☐ muscle pain ☐ mobility issues ☐ other: _____	**Neurology**: ☐ Normal ☐ headaches ☐ hydrocephalus ☐ seizures ☐ cerebral palsy ☐ other: _____
Development: ☐ Normal ☐ global delay ☐ motor delay ☐ sensory delay ☐ speech delay ☐ PT ☐ OT ☐ speech therapy ☐ early intervention ☐ autism spectrum disorder ☐ Asperger's syndrome ☐ other: _____	**Psychology issues**: ☐ Normal ☐ ADHD ☐ OCD ☐ bipolar ☐ depression ☐ behavior issues ☐ anxiety ☐ other: _____	

Diet History

If your child is an infant/toddler, please answer the following questions:	If your child is older than a toddler, please answer the following questions:
Is your child currently breast fed? ☐ No ☐ Yes If breastfed, how many feedings per day? Type of formula: Quantity of formula per bottle Number of feeds per day: Other foods:	How would you describe your child's diet? ☐ normal diet for age ☐ special diet, if so please explain: Any diet restrictions? ☐ No ☐ Yes If yes, please explain:

Is your child is on tube feedings?
☐ Yes ☐ No
If yes, please answer the following questions:

Is your child allowed to eat by mouth? ☐ Yes ☐ No
If not, please explain the reason:
☐ aspiration risk
☐ other

What is the type of tube feeding? ☐ NG tube ☐ G tube ☐ J tube

What formula do you currently use? _____
Please explain the feeding schedule:
☐ bolus feeds: How many times/day? _____ How many mls _____ run over _____ how much time?.
☐ continuous feeds:
_____ mls run over _____ at a rate of _____ mls/hour from _____ to _____ .

Has your child had any tests done for his current GI problem? If yes, please list tests below and bring copies of these results with you to your child's appointment.

_____

_____

_____

Please tell us anything else you think may be important for us to know about your child.

_____

_____

_____

Staff initials and date: _____
