34474-08

Children's Physician Group-Gastroenterology
Children's Specialty Services

GASTROENTEROLOGY NEW PATIENT VISIT FORM

Name_____

Date of Birth_____

MRN#_____

Account/HAR#_____

PATIENT IDENTIFICATION

New Visit Information (Parents - please fill out sections 1-7)

Patient Vitals (Office Use Only)

Temp:	HR:	RR:	BP:	Ht:_____|_%_____	Wt:_____|_%_____	Head Circ:____|_%____

Allergies: ☐ NKDA _____ **BMI:**_____\|_%_____

Are your immunizations up to date: ☐ Yes ☐ Not sure ☐ Missing doses ☐ do not immunize

Missing doses: _____

Has your child been exposed to anything: ☐ Yes ☐ No

If yes have they been exposed to: ☐ Measles ☐ Strep ☐ Chicken Pox ☐ Other: _____

Does your child have any of the following: ☐ MRSA ☐ VRE ☐ Cepacia ☐ None of those listed

Has the child or anyone in your immediate family traveled out of the country in the last 21 days ☐ Yes ☐ No

If yes where? _____

How often do you need to have someone help you read written materials and instructions from your doctor and/or pharmacy?
☐ Never ☐ Sometimes ☐ Often ☐ Always

Provided family with information on safety initiatives ☐ Yes

Okay to leave a message on voice mail? ☐ Yes ☐ No

In Pain now? ☐ Yes ☐ No	Score	Scale	Location/Quality/Duration

1. Background Information

Referring Physician: **Physician Phone:**

Mother: **Occupation:** **Age:**

Father: **Occupation:** **Age:**

Would you like to be contacted with lab results via email? ☐ Yes ☐ No **Email:**

Reason for Visit:

2. History of Present Illness (CIRCLE all that apply)

Stools:	Constipation	Stool Accidents	Blood in Stool
	# Stools per day:	Night-time Stools	Consistency: Hard Formed Loose
Pain:	Abdominal Pain	Location: Upper Mid Low	Pain Frequency: Daily Weekly Monthly
Reflux:	Spits Up	Heartburn	Vomiting / Nausea
Growth:	Weight Loss	Poor Wt Gain	Feeding Problem
Other:	Fever / Fatigue	Gtube	Missing School No Days:
Nutrition:	Regular Diet	Formula:	Diet Restrictions:
Gtube:	Type:	Size:	Rate:
Duration:	<1 month	1-3 months 3-6 months	>6months

History:

3. Past Medical History

Pregnancy Complications: ☐ Yes ☐ No List:

Birth History: Birth Weight: Premature Birth ☐ Yes ☐ No If Yes: how early?

Has your child ever had an operation ☐ Yes ☐ No List:

Has your child ever been hospitalized ☐ Yes ☐ No List:

Does your CHILD have any of the following conditions:

Asthma	☐ Yes ☐ No	Bleeding Disorder	☐ Yes ☐ No	Anemia	☐ Yes ☐ No
Eczema	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Celiac Disease	☐ Yes ☐ No
Heart Disease	☐ Yes ☐ No	Cancer or Leukemia	☐ Yes ☐ No	Joint Disease	☐ Yes ☐ No
Cystic Fibrosis	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No
Birth Defects	☐ Yes ☐ No	Inflammatory Bowel Dis	☐ Yes ☐ No	Cerebral Palsy	☐ Yes ☐ No
ADHD	☐ Yes ☐ No	Immunologic Disease	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Environmental Allergies	☐ Yes ☐ No	Thyroid Disease	☐ Yes ☐ No
Mood Disorder	☐ Yes ☐ No	Gastroesophageal Reflux	☐ Yes ☐ No	Seizure Disorder	☐ Yes ☐ No
Depression	☐ Yes ☐ No	Migraine Headaches	☐ Yes ☐ No	Down Syndrome	☐ Yes ☐ No

Other Past Medical History:

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4. Family History

Is there a Family History (ie Mother, Father, Siblings, Grandparents) of any of the following:

		Who?			Who?			Who?
Asthma	☐ Yes ☐ No		Bleeding Disorder	☐ Yes ☐ No		Anemia	☐ Yes ☐ No	
Eczema	☐ Yes ☐ No		High Blood Pressure	☐ Yes ☐ No		Celiac Disease	☐ Yes ☐ No	
Heart Disease	☐ Yes ☐ No		Cancer or Leukemia	☐ Yes ☐ No		Joint Disease	☐ Yes ☐ No	
Cystic Fibrosis	☐ Yes ☐ No		Low Blood Pressure	☐ Yes ☐ No		Liver Disease	☐ Yes ☐ No	
Birth Defects	☐ Yes ☐ No		Inflammatory Bowel Dis	☐ Yes ☐ No		Cerebral Palsy	☐ Yes ☐ No	
ADHD	☐ Yes ☐ No		Immunologic Disease	☐ Yes ☐ No		Kidney Disease	☐ Yes ☐ No	
Diabetes	☐ Yes ☐ No		Environmental Allergies	☐ Yes ☐ No		Thyroid Disease	☐ Yes ☐ No	
Mood Disorder	☐ Yes ☐ No		Gastroesophageal Reflux	☐ Yes ☐ No		Seizure Disorder	☐ Yes ☐ No	
Depression	☐ Yes ☐ No		Migraine Headaches	☐ Yes ☐ No		Down Syndrome	☐ Yes ☐ No	

Other Family History:

5. Social History

Number of adults in household:	**Smoking in home:** ☐ Yes ☐ No **Pets in home:** ☐ Yes ☐ No
Number of children in household:	**Ages of children:**
Is your child in daycare? ☐ Yes ☐ No	**Is your child in school?** ☐ Yes ☐ No **Grade:**

Extracurricular Activities:

6. Review of Systems (check all that apply)

☐ Fever ☐ Wt Loss ☐ Visual Problems ☐ ENT ☐ Heart ☐ Respiratory ☐ Hematologic ☐ Joints ☐ Neuro ☐ GU
☐ Diarrhea ☐ Vomiting ☐ Abdominal Pain ☐ Nausea ☐ Skin ☐ Constipation ☐ Food Allergies ☐ Jaundice ☐ Spitting up

Explain / Other:

7. Medications

Vitamins ☐ Yes ☐ No Herbal Supplements ☐ Yes ☐ No Probiotics ☐ Yes ☐ No If yes, list:

Nurse Signature: _____ Date:_____ Time:_____

Physical Examination (Office Use Only)

General: NAD, well developed, no distress	☐ Yes ☐ No	**Abnormal Findings**
HEENT: PERRL, conjunctiva clear, TM normal, oropharynx clear – no ulcers	☐ Yes ☐ No	
CV: RRR no murmur RESP: CTA bilaterally	☐ Yes ☐ No	
Abdomen: soft, non-tender, non-distended, no hepatosplenomegaly	☐ Yes ☐ No	
Rectal: Normal, no fissures, no fistulas, no skin tags Guaiac ☐ Pos ☐ Neg	☐ Yes ☐ No	
Skin: no lesion Neuro: normal tone, normal reflexes Lymph: no palp LNs	☐ Yes ☐ No	

Assessment / Management (Office Use Only)

Medications:

Labs:

Nutrition:

Follow up ☐ 3 months ☐ 6months ☐ As needed ☐ Nursing Education Completed

Nurse Signature: _____ Date:_____ Time:_____

Provider/Physician Signature: _____ Date: _____ Time: _____

Resident/Fellow Signature: _____ Date: _____ Time: _____