PennState Health
Milton S. Hershey Medical Center

PEDIATRIC GASTROENTEROLOGY NEW PATIENT QUESTIONNAIRE

Patient's Name: _____ Date of Birth: _____

Home Phone: _____ Age (year/month): _____

Mom/guardian's Name: _____ Dad/guardian's Name: _____

Work #: _____ Work #: _____

In a few words, why are you here to see us today? _____

_____

_____

Birth History:

Birth Weight:

Full term ☐ Yes ☐ No How early?

Were there any problems with:

Pregnancy	☐ Yes	☐ No	Explain: _____
Labor	☐ Yes	☐ No	Explain: _____
Were there any problems in the nursery?	☐ Yes	☐ No	Explain: _____
Any jaundice	☐ Yes	☐ No	Explain: _____
Constipation	☐ Yes	☐ No	Explain: _____

Feeding History:

What was your child first fed as a newborn (breast or formula)? _____

How would you describe his or her current diet? _____

Are any foods restricted from the diet? _____

Growth and Development:

Has your child's growth and development been normal? _____

At what age did he or she: Roll over _____

Sit up _____

Pull to standing _____

Say first words _____

Put words together _____

Become toilet trained _____

Walked _____

Medical History:

Has your child ever been hospitalized?	☐ Yes	☐ No	Explain: _____
Has the child had a surgery?	☐ Yes	☐ No	Explain: _____
Is your child on any medications?	☐ Yes	☐ No	Explain: _____
Does your child have any allergies?	☐ Yes	☐ No	Explain: _____
Are immunizations up to date?	☐ Yes	☐ No	Explain: _____

Has your child had any serious problems with:

Eyes, ears, nose or throat?	☐ Yes	☐ No	Explain: _____
Breathing (pneumonia, asthma, etc.)?	☐ Yes	☐ No	Explain: _____
Heart or blood pressure?	☐ Yes	☐ No	Explain: _____
Kidney or bladder infection?	☐ Yes	☐ No	Explain: _____
Joints, bones or muscles?	☐ Yes	☐ No	Explain: _____
Seizures?	☐ Yes	☐ No	Explain: _____
Bleeding disease?	☐ Yes	☐ No	Explain: _____

Family history? _____

_____

Who lives at home with the patient? _____

Names and ages of brothers and sisters:_____

_____

Has anyone in the family suffered from:

Food Allergies?	☐ Yes	☐ No	Explain: _____
Asthma?	☐ Yes	☐ No	Explain: _____
Bleeding disease?	☐ Yes	☐ No	Explain: _____
Cystic fibrosis?	☐ Yes	☐ No	Explain: _____
Celiac disease?	☐ Yes	☐ No	Explain: _____
Chronic diarrhea?	☐ Yes	☐ No	Explain: _____
Constipation?	☐ Yes	☐ No	Explain: _____
Crohn's disease?	☐ Yes	☐ No	Explain: _____
Ulcerative colitis?	☐ Yes	☐ No	Explain: _____
Ulcers?	☐ Yes	☐ No	Explain: _____
Jaundice?	☐ Yes	☐ No	Explain: _____
Hepatitis?	☐ Yes	☐ No	Explain: _____
Liver disease?	☐ Yes	☐ No	Explain: _____
Cirrhosis of the liver?	☐ Yes	☐ No	Explain: _____
Pancreatitis?	☐ Yes	☐ No	Explain: _____
Gallstones?	☐ Yes	☐ No	Explain: _____
Chronic abdominal pain?	☐ Yes	☐ No	Explain: _____
"Spastic colon"?	☐ Yes	☐ No	Explain: _____
"Irritable bowel"	☐ Yes	☐ No	Explain: _____
Polyps?	☐ Yes	☐ No	Explain: _____
Reflux?	☐ Yes	☐ No	Explain: _____
Seizures?	☐ Yes	☐ No	Explain: _____
Sinus problems?	☐ Yes	☐ No	Explain: _____

Do you have any pets? _____

Does anyone at home smoke?_____

What is the source of your drinking water? (well, city supply, etc.): _____

For school age children:

What grade is your child in?_____

How is his or her attendance record? _____

_____

How is his or her school performance? _____

_____

To what physician(s) should we send a report of our evaluation?

Doctor's name:_____ Telephone: _____

Address:_____

Is there any other information you would like us to know? _____

_____

Signature:_____ Date:_____ Time: _____

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