

PALM BEACH PEDIATRIC GASTROENTEROLOGY

PATIENT NAME		
REASON FOR VISIT		
PAST MEDICAL HISTORY		
List any known medical problems (ie. Asthma, reflux, Crohns Disease, Ulcerative Colitis, Diabetes, Thyroid Disease, ADHD, etc.)		
List any surgeries or hospitalizations		
Birth: Full Term Premature Weeks Gestation _____	Delivery: Vaginal C-Section	Birth Weight
Pregnancy/Delivery Complications:		Child passed stool (Meconium) within 24 hours after birth? <input type="checkbox"/> Yes <input type="checkbox"/> No

Medications <small>Please list all current medications, including over the counter medication (ie Tylenol), vitamins and herbal therapies and doses</small>		Allergies <small>Please list all allergies to medications and food and their corresponding reactions ie. hives, difficulty breathing.</small>	
Medication	Dose and Frequency	Allergy	Reaction

Are the patient's immunizations up to date? Yes No

FAMILY AND SOCIAL HISTORY

Has anyone in the patient's family had any of the following? If yes, please check the box and list the relationship to the patient

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|---|---|--|
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Celiac Disease | <input type="checkbox"/> Colon Polyps/Colon Cancer |
| <input type="checkbox"/> Food Allergies | <input type="checkbox"/> Stomach Ulcers | <input type="checkbox"/> Gallstones/Liver Issues |
| <input type="checkbox"/> Ulcerative Colitis | <input type="checkbox"/> GERD (reflux) | <input type="checkbox"/> Lactose Intolerance |
| <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Irritable Bowel Syndrome | <input type="checkbox"/> Anxiety/Depression | <input type="checkbox"/> Migranes |

List any other medical problems

Does anyone smoke around your child? Yes No Does your child smoke? Yes No

Does your child drink alcohol? Yes No

Does your child attend school? Yes No If yes, which school and what grade? _____

Has there been a recent change in your child's performance/behavior? Yes No

Is there any stress at home/school? Yes No If yes, please describe _____

With whom does the child live? _____