Rady Children's Hospital San Diego

**Specialty Clinics**
Rady Children's Hospital
3020 Children's Way
San Diego, CA. 92123

DTF740

PATIENT INORMATION

Name: _____
MR#: _____ Finance: _____
DOB: _____
MD: _____

# Gastro Patient Intake Questionnaire

**Date:** _____ **Patient's Name:** _____

**Age:** _____ **Sex:** ☐**Male** ☐**Female**

**Briefly describe (≤ 1 sentence) the reason for today's visit?** _____

_____

**Indicate all studies you have completed to evaluate this problem:**

☐Blood work ☐Urine studies ☐Stool studies ☐Radiology studies

## CURRENT MEDICATIONS (Prescription and Over the Counter)

| Name | Dose | Frequency | Duration |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

## COMPLEMENTARY/ALTERNATIVE MEDICINE
### List Dietary, Vitamin or Herbal Supplements

| Name | Dose | Frequency | Duration |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**Check any of the following you have been using:**

☐Acupuncture ☐Homeopathy ☐Chiropractic ☐Biofeedback ☐Cognitive Behavioral Therapy
☐Healing or Therapeutic Touch ☐Massage ☐Reflexology ☐Psychotherapy

**DRUG ALLERGIES:** _____

**FOOD ALLERGIES:** _____

**ENVIRONMENTAL ALLERGIES:** _____

**PAST MEDICAL HISTORY:**

Were there any problems during the pregnancy with this child? ☐Yes ☐No
If Yes, briefly explain: _____

Was there exposure during pregnancy to smoking, alcohol, drugs or medications? ☐Yes ☐No
If Yes, briefly explain: _____

Please list approximate weeks of pregnancy that patient was born: _____ Birth Weight:_____lbs_____oz

If the patient is here for constipation, how many day(s) old were they when they had their very first bowel movement (meconium) after birth? _____

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# Gastro Patient Intake Questionnaire (continued)

| Major Medical Problems or Illnesses | Date of Diagnosis |
|---|---|
| | |
| | |
| | |

**PAST HOSPITALIZATIONS**

| Reason | Date | Hospital Name |
|---|---|---|
| | | |
| | | |
| | | |

**PAST SURGERIES**

| Reason | Date | Hospital Name & Surgeon |
|---|---|---|
| | | |
| | | |
| | | |

**DIET / NUTRITIONAL HISTORY:**

Was the patient breast fed as an infant? ☐Yes ☐No If yes, until how many months old? _____

Please indicate all sources of water consumed: ☐ Tap ☐Well ☐Bottled

Is the patient on any restricted diet? ☐ Yes ☐No If Yes, briefly explain:_____

For patients who are infants:

What is their current nutrition? (Check all that apply): ☐Breastmilk ☐Formula ☐Table food

If formula fed, list current formula:_____ Ounces consumed in 24 hrs_____

Please list other formulas tried and date: _____

**For patients who are children or teens:** (Check all that apply)

| Type of Milk Consumed | Amount consumed (ounces per day) |
|---|---|
| Whole Cow's Milk ☐ | |
| 2% Cow's Milk ☐ | |
| 1% Cow's Milk ☐ | |
| Skim Cow's Milk ☐ | |
| Soy Milk ☐ | |
| Rice Milk ☐ | |
| Other ☐ | |

**Non-oral routes of nutrition (Check all that apply now):**

| Route | Feeding Schedule |
|---|---|
| G-Tube ☐ | |
| TPN ☐ | |

**Immunization/Exposure History**

| Type | Date |
|---|---|
| Hepatitis A Vaccine | |
| Hepatitis B Vaccine | |
| Diptheria / Pertussis / Tetanus Vaccine | |
| Mumps / Measles / Rubella Vaccine | |
| Varicella (chickenpox) Vaccine | |
| Tuberculosis Skin Test (PPD) | |

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# Gastro Patient Intake Questionnaire (continued)

**REVIEW OF SYSTEMS: Please check problems on the list below, which the patient has had within the past year.**

| General | | Gastrointestinal | |
|---|---|---|---|
| Recent acute illness | | Appetite problems | |
| Fever / chills / sweats | | Nausea | |
| Fatigue or weakness | | Vomiting | |
| Excessive thirst or urination | | Heartburn, reflux or spitting up | |
| Unexplained weight loss or gain | | Excessive burping | |
| Swollen glands | | Pain or difficulty swallowing | |
| Pale | | Abdominal pain | |
| Delay in development | | Abdominal distension / bloating / gassiness | |
| **Allergy** | | Jaundice or yellowness of skin | |
| Asthma | | Diarrhea | |
| Eczema | | Constipation | |
| Hives | | Bloody stools | |
| Hayfever | | Black or tarry stools | |
| **Eyes** | | Pale stools | |
| Vision problems | | Greasy stools | |
| Eye pain / burning / tearing / itching | | Fecal incontinence or soiling | |
| **Ear / Nose / Throat** | | Rectal prolapse | |
| Hearing problems / ringing in ears | | **Heart/Lung** | |
| Ear pain | | Palpitations | |
| Chronic or recurrent ear infections | | Chest pain or pressure | |
| Congestion or nasal discharge | | Difficulty breathing or loud breathing | |
| Snoring | | Coughing | |
| Sore throat | | Wheezing | |
| Voice hoarseness | | Excessive hiccups | |
| Croup | | **Blood / Lymphatic** | |
| Mouth ulcers | | Unexplained lumps | |
| Problems with teeth or gums | | Easy bruising / bleeding | |
| **Musculoskeletal / Skin** | | **Neurologic / Psychiatric** | |
| Rashes | | Headache | |
| Itchiness | | Dizziness | |
| Muscle pain | | Seizures | |
| Back pain | | Loss of coordination or imbalance | |
| Neck Pain | | Memory loss | |
| Weakness in arms or legs | | Waking from sleep or problems with sleeping | |
| Joint pain / swelling / redness | | Sad mood or depression | |
| **Genitourinary** | | Anxiety or stress | |
| Urinary incontinence | | **Gynecologic (females only)** | |
| Blood in urine | | Vaginal discharge | |
| Pain with urination | | Age of onset of periods / menses-list here | |
| Frequent urination | | Problems with periods / menses | |
| | | Medication use for menstrual problems | |
| **Other** (please list): | | | |
| | | | |
| | | | |

**ROS Reviewed with Patient:**

| | | | | | | |
|---|---|---|---|---|---|---|
| **Provider Initials** | | | | | | |
| **Date** | | | | | | |

**SOCIAL HISTORY:**

Where does the patient live? (Check all that apply)

☐Apartment ☐house ☐farm ☐military base ☐group home ☐boarding school ☐other: _____

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# Gastro Patient Intake Questionnaire (continued)

List below those who live with the patient:

| Relationship to patient | Age | Sex | Smoker? |
|---|---|---|---|
| | | Male ☐ Female ☐ | Yes ☐ No ☐ |
| | | Male ☐ Female ☐ | Yes ☐ No ☐ |
| | | Male ☐ Female ☐ | Yes ☐ No ☐ |
| | | Male ☐ Female ☐ | Yes ☐ No ☐ |
| | | Male ☐ Female ☐ | Yes ☐ No ☐ |
| | | Male ☐ Female ☐ | Yes ☐ No ☐ |

Father's occupation: _____

Mother's occupation: _____

Religious Affiliation: _____

Are there other caregivers besides the parents? ☐Yes ☐No

Please indicate which if any pets are in the home: (check all that apply or list others)

☐Dogs ☐cats ☐reptiles ☐birds ☐Other: _____

**Travel History:** (check all that apply within the past year)

☐Within US ☐Camping ☐Mexico ☐Other countries (list): _____

What type of school is the patient in? ☐Public ☐Private ☐Home-school

What grade is the patient in school? _____

What is the patient's school performance like? ☐Honors ☐Average ☐Passing ☐Failing

| School Related Questions Within the Past Year | Yes | No |
|---|---|---|
| Is the patient in special education? | | |
| Any problems with school performance? | | |
| Any problems with school attendance? | | |

| Activity Related Questions Within the Past Year | Yes (list hours per week) | No |
|---|---|---|
| Does the patient take part in after school activities? | | |
| Does the patient take part in physical education? | | |
| Does the patient exercise outside of school? | | |
| Does the patient regularly watch TV/videos or use the computer? | | |

Any stress in the patient's life? ☐Yes ☐No

If Yes, check all that apply: ☐Home ☐School ☐Friends ☐Other:_____

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# Gastro Patient Intake Questionnaire (continued)

**FAMILY HISTORY: Please indicate with an "x" family members who have had any of the following conditions:**

| Medical Condition | Mom | Dad | Sister (list age) | Brother (list age) | Grandma | Grandpa | Other relatives (list relationship) |
|---|---|---|---|---|---|---|---|
| Alcoholism | | | | | | | |
| Anesthesia problems | | | | | | | |
| Arthritis | | | | | | | |
| Asthma | | | | | | | |
| Birth Defects | | | | | | | |
| Sudden Infant Death (SIDS) / Stillborn or Spontaneous Abortions | | | | | | | |
| Bleeding problems | | | | | | | |
| Cancer (type and age of onset) | | | | | | | |
| Celiac Disease (wheat or gluten sensitivity) | | | | | | | |
| Constipation | | | | | | | |
| Cystic Fibrosis | | | | | | | |
| Developmental Delays | | | | | | | |
| Depression | | | | | | | |
| Anxiety Disorder | | | | | | | |
| Schizophrenia | | | | | | | |
| Bipolar Disease | | | | | | | |
| Diabetes (childhood onset) | | | | | | | |
| Diabetes (adult onset) | | | | | | | |
| Eczema | | | | | | | |
| Epilepsy / Seizures | | | | | | | |
| Environmental Allergies | | | | | | | |
| Food Allergies | | | | | | | |
| Genetic Diseases | | | | | | | |
| Heart Problems | | | | | | | |
| High Blood Pressure | | | | | | | |
| High Cholesterol | | | | | | | |
| Hirschsprung's Disease | | | | | | | |
| Inflammatory Bowel Disease | | | | | | | |
| Irritable Bowel Syndrome or Spastic Colon | | | | | | | |
| Kidney Problems | | | | | | | |
| Lupus or other autoimmune disorders | | | | | | | |
| Liver Disease | | | | | | | |
| Mental Retardation | | | | | | | |
| Migraine headaches | | | | | | | |
| Overweight or Obesity | | | | | | | |
| Pancreas Problems | | | | | | | |
| Rheumatoid arthritis | | | | | | | |
| Stroke | | | | | | | |
| Tuberculosis | | | | | | | |
| Thyroid Problems | | | | | | | |
| Other: | | | | | | | |

Name of person filling form out

Signature

Relationship to Patient

Date