CHILDREN'S NATIONAL
GASTROENTEROLOGY DEPARTMENT
NEW PATIENT SELF INFORMATION

(Please complete both sides of this form and give it to the nurse at your visit)

Today's Date:_____

PARTICULARS:

Patient name:_____ **Name of person filling out form:**_____
Birthdate:_____ **Relationship to the patient:**_____
_____
Age:_____ **Sex:**_____

What is your child's main problem?_____
_____

Describe the symptoms and duration:_____
_____

Other concerns:_____
_____
_____

PAST MEDICAL HISTORY:

Birth:

Birth weight: _____Full Term: Yes ___ No ___ (if no, # of weeks)?_____
Any problems during pregnancy? Yes ____ No ____ labor? Yes ____ No ____ delivery? Yes ____ No ____
Did your child pass green stool in the first 24hrs? Yes ____ No ____
Jaundice (yellow discoloration)? Yes ____ No ____
Breathing difficulties? Yes ___ No ___
Did you and your child go home together? Yes ___ No ___ (if no how many weeks before discharged)? ____

List prior hospitalizations in order:

Age	Problem	Hospital Name	Dates in Hospital

(If more than 3, please indicate the number of hospitalizations) _____

List outpatient surgeries?

_____
_____

Blood transfusion? Yes_____ No_____ Immunizations up to date? Yes_____ No

Any known heart condition? (example: murmur)_____

LIST ALLERGIES:

Drug_____

Food_____

Inhalant/seasonal_____

FEEDING/DIET (amount and how often):_____
_____
_____

LIST ALL MEDICATIONS CURRENTLY TAKING:

Drug name	How much and often	Start Date

SYSTEMIC REVIEW:

❑Diabetes ❑ Developmental Delay ❑Asthma ❑Autism ❑ADHD ❑Other

(Please check if applicable)

General		Bad Breath		Heart Murmur		**Joint**	
Fever		Mouth Ulcers/Sore Throat		Poor Exercise tolerance		Joint Pain	
Tiredness		Weight Loss/Poor Weight Gain		Palpitations		Joint Stiffness	
Pale		Sore around anus		**ENT**		Scoliosis	
GI		Hemorrhoids		Ear Pain/Otitis Media		**Neurological**	
Vomiting/Nausea		**Liver**		Runny Nose		Headache	
Abdominal Pain		Jaundice/Yellow Discoloration		Sinus Problems		Seizures	
Gassiness/Bloating		Right Upper Quadrant Pain		Hearing Problems		Migraine	
Diarrhea		**Respiratory**		**Eye**		Developmental Delay	
Constipation		Chest Pain		Vision Problems		Wheel chair bound	
Soiling		Wheezing/Coughing		Eye Pain		Learning difficulty	
Blood in Stool		Difficulty In Breathing		**Skin**		V-P Shunt	
Black Stool		Choking/Gagging		Eczema		**Puberty**	
White Stool		**Cardiac**		Rashes		Pubic hair	
Poor Appetite/Food Aversion		Turning Blue/Pale		Itching		Menses	

FAMILY HISTORY

List the names of everyone living with the child? Including parent(s), brother(s), sister(s), etc.	Relation to Child	Age	Sex	List medical problems (include allergies, migraines, gastrointestinal & other)	Occupation or grade

SOCIAL HISTORY:

Name of the child's **legal guardian? (If applicable)**:___

Exposure to well or spring water?_____ Any travel outside the country?_

Exposure to tobacco smoke?_____ Are there any pets?_____

What grade is your child in? _____ School Name:_____

_____

The child's school performance is:_____ excellent, _____ good, _____ fair, _ poor

OTHER RELEVANT:

List tests/studies performed: (including blood work, urine/stool studies and X-ray/ultrasound?

_____

_____

_____

Doctor/Nurse Practitioner's Signature:_____