



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

DTF740



PATIENT INFORMATION

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

Gastro Patient Intake Questionnaire

Date: _____ Patient's Name: _____

Age: _____ Sex: Male Female

Briefly describe (\leq 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? _____



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: (Circle 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 (Circle all that apply now):

Route	Feeding Schedule
G-Tube	
TPN	

Immunization/Exposure History

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

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: _____

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: _____

FAMILY HISTORY: Please indicate with a check 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