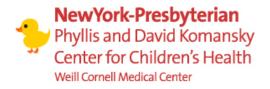
# **Pediatric Gastroenterology & Nutrition**



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# FOLLOW UP VISIT QUESTIONNAIRE

Please complete this questionnaire. It will be an important part of your child's medical record.

Complete Your Child's Name:	
Child's DOB:	Child's Age:

# Pediatrician's Name:

Pediatrician's Address:

Telephone:

# **A. Current Medical History**

1) List all medications (include over the counter and herbal therapies).

Drug	Dose	How often

2. List any hospitalizations that your child has had. Include his/her age, where hospitalized, and the reason for the hospitalization.

Drug Allergies:

3. Are immunizations up to date?

Yes No

4. List any **RECENT** surgeries/procedures with the dates performed that your child has had. Include those done as an outpatient.

# **B.** Family History

1. Has anyone in the patient's family (or relative) had any of the following? If yes, check the box and list the person's relationship to the patient next to the problem.

- Migraine headaches
  Seizures
  Mental retardation/developmental delay
  Asthma, Emphysema
  Cystic Fibrosis
  Sickle cell disease or trait
  Cancer (list type)
- High blood pressure
   Heart disease or stroke
   Diabetes
- Anemia
- High cholesterol
- Constipation
- Polyps

Gallstones/ gall bladder problem
 Gastritis/ulcer
 Colitis, Crohns disease
 Celiac disease
 Liver problems
 Blood in stool
 Irritable bowel syndrome

2. Is there any other disease/illness that runs in the family?

# C. Social History: (ANY RECENT CHANGES)

1. Who lives in the same household with the patient?

Name	Age	Relationship to patient	Any health problems

			_	
4 Any unusu	al stresses at ho	ome or schoo	12   <b>Y</b>	es

If yes, please explain.

#### D. Review of Systems: Please check any of the following that are problems for your child:

# (IF NOTHING IS CHECKED IT IS ASSUMED NEGATIVE.)

#### General

Recurrent fevers/temperatures	
Weight loss	
Weight gain	
<u>Skin</u>	
Skin rashes	

0
Acne

Acne
Easy bruising

#### Ears, Nose, Throat

🗌 Ear pain
Ear infections
Discharge from ears
□ Nose bleeds
Sinus problems
Mouth Ulcers
Trouble swallowing
Hoarseness
Sour taste in mouth
Sore throat
Dental problems

# Heart/ Blood vessels

□ No

Heart murmur Heart problems Chest pain Palpitations (fast heart beat) Irregular heart beat Blood pressure problems

#### **Genital/Urinary System**

- Pain/burning with urination Blood in urine Increased frequency or amount of urine Swelling/retaining water Other urinary tract or kidney problems Menstrual problems Age at first menstrual period
- Date last menstrual periodended

#### Endocrine (Glands)

- Thyroid problems
- Poor growth

Other hormone/gland problems

#### Neurologic (Brain / Nerves)

- Developmental delay Headaches Seizures Dizziness **Fainting** ADHD (hyperactivity) Decreased sensation Decreased muscle strength
- Other neurologic problems

#### 2. Are the parent(s): Single Married

Divorced

# Separated Remarried

3. School History:

A) Grade in school:

- B) Performance/Grades
- C) Recent change in behavior/performance?

# Breathing/ Lungs/ Chest

- Coughing
- ☐ Wheezing
- Asthma
- Shortness of breath
- Apnea (stops breathing)
- Pneumonia

# **Breasts**

- Discharge from nipples
- Breast lumps/masses
- Other skin problems

# <u>Musculoskeleta</u>l

- Joint problems
- Weakness
- Scoliosis (curved spine)

#### Allergy/Immune System

Allergies Immune problems Frequent infections Unusual infections

#### Hematologic (Blood problems)

- Anemia
- Received blood transfusions
- Easy bruising
- Swollen lymph nodes
- Bleeding disorders/easy bleeding

Constipation (hard or infrequent stools) Soiling underpants

Gastrointestinal (Stomach / Intestines)

- Diarrhea
- □ Vomiting/spitting up
- Heartburn
- Blood in stool
- Difficulty swallowing
- Stomach pain
- Nausea
- Liver problems/jaundice/hepatitis

# **E. Feeding History:**

Is your child's appetite normal or decreased?

# F. Stooling history:

How often does your child stool now?

When was your child's last bowel movement?

	Does your child have accidents (soils underpants)? Is your child's stool malodorous (smells awful)?					Yes	🗌 No	
					☐ Yes		🗌 No	
	What is the consistency of your child's stool?			🗌 Hard	□ Soft	Loose	□ Watery	
	What is the color of your child's stool?	Brown	☐ Yellow	Green	Orange	🗌 Red	🗌 Black	
Domon	t/Dationt Signature			1	Data			

Parent/Patient Signature	Date
X	
Physician Signature	Date

# **Pharmacy Information**

So that you and your physician may take advantage of e-prescribing, we need you to provide information on the pharmacy that you choose to use to fill you or your child's prescriptions. Electronic prescription requests are more efficient, accurate and cost effective. Feel free to speak with your physician if you have additional questions.

Update

Date:

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Patient Name:

NYH #:

**PRIMARY** 

Pharmacy Name:

Address:

Phone Number:

Fax Number:

**<u>SECONDARY</u>** (if applicable) Pharmacy Name:

Address:

Phone Number:

Fax Number: