



Welcome to Progressive Child & Adolescent Gastroenterology  
**New Patient Questionnaire For Abdominal Pain**

Patient Name: \_\_\_\_\_ D.O.B: \_\_\_\_\_ Sex: M F

Person filling out this form: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home or Cell Phone number: \_\_\_\_\_ Best time to contact: AM PM

Pediatrician: \_\_\_\_\_ Previous GI specialists: \_\_\_\_\_

**Abdominal Pain**

How long has this been a problem?  2 weeks  1-2 months  3-4 months  5-7 months

10-12 month  Other: \_\_\_\_\_

Previous treatments: \_\_\_\_\_ Duration of Use: \_\_\_\_\_

Location of pain:  All over abdomen  Around umbilicus

Upper abdomen:  Middle  Left  Right

Lower abdomen:  Middle  Left  Right

Character of pain:  Dull  Sharp  Squeezing

Timing of pain:  Constant  Intermittent

Relief of pain by:  Medication  Passing of stools  Food

Worsened by:  Food  Lying down

**Other associated symptoms:**

Nausea  Vomiting  Constipation  Diarrhea  Blood in stool  Fever

Weight loss  Rash  Painful urination  Frequent urination  Blood in urine

Back pain  Vaginal discharge  Penile discharge  Other: \_\_\_\_\_

**Please list your child's current medications (including over the counter medications, vitamins, herbal remedies, birth control and holistic supplements):**

Name	Dose/Strength	How often?	Start Date


**Does your child have any known allergies?**  No  Yes (If yes, indicate below)

Allergy	Name of Food or Medication	What was the reaction?
<b>Drugs</b> <input type="checkbox"/> No <input type="checkbox"/> Yes		
<b>Foods</b> <input type="checkbox"/> No <input type="checkbox"/> Yes		
<b>Other</b>		

**Past Medical History (Check all that apply):**

**GI:**  GERD  Constipation  Diarrhea  Pyloric Stenosis  Volvulus  Crohn's  
 Ulcerative Colitis  Irritable Bowel Syndrome  Intussusception  Excessive weight gain

**Heart:**  Murmur  Palpitations  Vasovagal attacks  Chest pain  Kawasaki's

**Lung:**  Pneumonia  Bronchiolitis  Aspiration Pneumonia  Cystic Fibrosis  Apnea  
 Asthma  Apparent Life Threatening Event (ALTE)  Whooping Cough  Tuberculosis

**Musculoskeletal:**  Rheumatoid Arthritis  Systemic Lupus Erythematosus  Scleroderma  
 Rickets  Juvenile Rheumatoid Arthritis  Marfan's Syndrome  Ehlers-Danlos  
 Muscular dystrophy

**Neuro:**  Seizure disorders  Cerebral Palsy  Autism/Asperger's  Autism spectrum disorder  
 Hydrocephalus  Meningitis  Tourette syndrome  Tic  Encephalitis

**Psych:**  Anxiety  Depression  ADD  ADHD  ODD  Bipolar disorder

**Endocrine:**  Diabetes  Hypothyroidism  Hyperthyroidism  Failure to thrive  GH deficiency

**Other (please. specify)** \_\_\_\_\_

**Past Surgical History (Check all that apply):**

Appendectomy  Inguinal hernia repair  Umbilical Hernia Repair  Tympanostomy  
 Tonsillectomy  Adenoidectomy  Lacrimal duct dilation  Cholecystectomy  
 Splenectomy  Congenital heart repair  Diaphragmatic hernia repair  
 Tracheo-esophageal repair  Necrotizing enterocolitis surgery  Orchiopexy  
 Imperforate anus surgery  Cleft lip/palate repair  Club foot repair  
 Esophageal atresia repair  Esophagomyotomy  Gastrochisis repair  
 Other (specify) \_\_\_\_\_

Has your child ever been admitted to a hospital (excluding ER visit)?  No  Yes (specify below)

When?	Which hospital?	Reason for Admission

**Immunization History of your child**

Up to date  Delayed  Withheld (please indicate reason):  Medical reason  Personal reason

**Pregnancy History:**

Were there any complications during pregnancy in the mother?  No  Yes (Please check all that apply)

- Gestational Diabetes  Cervical incompetence  Low amniotic fluid
- Elevated blood pressure  Polyhydramnios  Pre-eclampsia
- Hyperemesis Gravidarum  Appendicitis  Gallstones
- Pre-term contractions  Cholecystectomy  Placenta previa

Other (please specify) \_\_\_\_\_

**Birth History:**

Full-term  Premature Estimated gestational age in weeks: \_\_\_\_\_

How was the baby delivered?

Vaginal  Vacuum/forceps assist  Cesarean (Please indicate reason \_\_\_\_\_)

**Baby's birth weight** \_\_\_\_\_ lb \_\_\_\_\_ oz

**Were there any complications with your baby at birth?**  No  Yes

If yes, please check all that apply.

- Jaundice  Difficulty in breathing  Feeding difficulties  Meconium aspiration
- Hypoglycemia  Ventilator Use (If yes, how long? \_\_\_\_\_)  Seizures at birth
- Other (please specify) \_\_\_\_\_

**Was your baby in the NICU?**  No  Yes

If yes, how long was your baby in the NICU? \_\_\_\_\_

What was the main diagnosis? \_\_\_\_\_ What was the treatment? \_\_\_\_\_

**When did your baby have the first bowel movement (meconium)?**

24-48 hours old     48-72 hours old     Greater than 72 hours     Not sure

**Were any interventions needed?**    No     Yes

If yes, what was it?    Rectal tube     Suppository

**Family history:**

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

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Asthma                       | <input type="checkbox"/> Childhood death         | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Celiac disease               | <input type="checkbox"/> Crohn's Disease         | <input type="checkbox"/> Acid reflux         |
| <input type="checkbox"/> Constipation                 | <input type="checkbox"/> Colon Cancer            | <input type="checkbox"/> Chronic diarrhea    |
| <input type="checkbox"/> Hirschsprung's Disease       | <input type="checkbox"/> Gallstones              | <input type="checkbox"/> Pancreatitis        |
| <input type="checkbox"/> Stomach ulcers               | <input type="checkbox"/> Irritable Bowl Syndrome | <input type="checkbox"/> Lactose intolerance |
| <input type="checkbox"/> Polyps                       | <input type="checkbox"/> Ulcerative Colitis      | <input type="checkbox"/> Liver Disease       |
| <input type="checkbox"/> Thyroid Disease              | <input type="checkbox"/> Jaundice                | <input type="checkbox"/> Hepatitis           |
| <input type="checkbox"/> Cirrhosis                    | <input type="checkbox"/> Cystic Fibrosis         | <input type="checkbox"/> Anemia              |
| <input type="checkbox"/> Other (Please specify) _____ |  |  |

**Review of Systems**

**If there are any symptoms, please check the box (es).**

<p><b>General</b>   <input type="checkbox"/> Normal</p> <p><input type="checkbox"/> fever</p> <p><input type="checkbox"/> excessive sweating</p> <p><input type="checkbox"/> fatigue/tired</p> <p><input type="checkbox"/> exercise intolerance</p> <p><input type="checkbox"/> Other: _____</p>	<p><b>Skin</b>   <input type="checkbox"/> Normal</p> <p><input type="checkbox"/> eczema</p> <p><input type="checkbox"/> dry skin</p> <p><input type="checkbox"/> acne</p> <p><input type="checkbox"/> bruising</p> <p><input type="checkbox"/> hair loss</p> <p><input type="checkbox"/> itching</p> <p><input type="checkbox"/> jaundice</p> <p><input type="checkbox"/> diaper rash</p> <p><input type="checkbox"/> Other: _____</p>	<p><b>Eyes</b>   <input type="checkbox"/> Normal</p> <p><input type="checkbox"/> glasses</p> <p><input type="checkbox"/> contact lenses</p> <p><input type="checkbox"/> light sensitivity</p> <p><input type="checkbox"/> pink eye</p> <p><input type="checkbox"/> discharge</p> <p><input type="checkbox"/> itching of eyes</p> <p><input type="checkbox"/> Other: _____</p>
<p><b>Ears, Nose, &amp; Throat</b>   <input type="checkbox"/> Normal</p> <p><input type="checkbox"/> hearing loss</p> <p><input type="checkbox"/> ear pain</p> <p><input type="checkbox"/> ear infections</p> <p><input type="checkbox"/> nose bleeds</p> <p><input type="checkbox"/> sinus infections</p> <p><input type="checkbox"/> sleep apnea</p> <p><input type="checkbox"/> trouble swallowing</p> <p><input type="checkbox"/> tooth decay</p> <p><input type="checkbox"/> mouth sores</p> <p><input type="checkbox"/> hoarseness</p> <p><input type="checkbox"/> Other: _____</p>	<p><b>Respiratory</b>   <input type="checkbox"/> Normal</p> <p><input type="checkbox"/> wheezing</p> <p><input type="checkbox"/> asthma</p> <p><input type="checkbox"/> persistent coughing</p> <p><input type="checkbox"/> shortness of breath with unusual exertion</p> <p><input type="checkbox"/> shortness of breath for no reason</p> <p><input type="checkbox"/> pneumonia</p> <p><input type="checkbox"/> Other: _____</p>	<p><b>Endocrine</b>   <input type="checkbox"/> Normal</p> <p><input type="checkbox"/> weakness/tired</p> <p><input type="checkbox"/> hyperactive</p> <p><input type="checkbox"/> hot sensitivity</p> <p><input type="checkbox"/> cold sensitivity</p> <p><input type="checkbox"/> increased frequency or amount of urine</p> <p><input type="checkbox"/> menstrual irregularity</p> <p><input type="checkbox"/> poor growth</p> <p><b>-Age when periods started</b> _____</p> <p><b>-Cycles</b>   <input type="checkbox"/> Regular   <input type="checkbox"/> Irregular</p> <p><input type="checkbox"/> Other: _____</p>

<b>Urinary System</b> <input type="checkbox"/> Normal <input type="checkbox"/> kidney failure <input type="checkbox"/> pain/burning with urination <input type="checkbox"/> increased frequency or amount of urine <input type="checkbox"/> swelling/retaining water <input type="checkbox"/> urinary tract infection <input type="checkbox"/> bedwetting <input type="checkbox"/> day time wetting <input type="checkbox"/> Other: _____	<b>Gastrointestinal</b> <input type="checkbox"/> Normal <input type="checkbox"/> trouble with bowel movement/constipation <input type="checkbox"/> diarrhea <input type="checkbox"/> nausea/vomiting <input type="checkbox"/> excess weight gain <input type="checkbox"/> weight loss, how much _____ <input type="checkbox"/> poor appetite <input type="checkbox"/> excessive appetite <input type="checkbox"/> gassiness <input type="checkbox"/> burping <input type="checkbox"/> feeling full after a small amount <input type="checkbox"/> rectal bleeding <input type="checkbox"/> Other: _____	<b>Cardiovascular</b> <input type="checkbox"/> Normal <input type="checkbox"/> chest pain <input type="checkbox"/> palpitations <input type="checkbox"/> heart beats fast for no reason <input type="checkbox"/> fainting <input type="checkbox"/> heart murmur <input type="checkbox"/> congenital heart disease <input type="checkbox"/> heart surgery <input type="checkbox"/> hypertension <input type="checkbox"/> Other: _____
<b>Musculoskeletal</b> <input type="checkbox"/> Normal <input type="checkbox"/> bone problems <input type="checkbox"/> scoliosis <input type="checkbox"/> joint problems <input type="checkbox"/> muscle pain <input type="checkbox"/> mobility issues <input type="checkbox"/> loose joints <input type="checkbox"/> increased flexible <input type="checkbox"/> Other: _____	<b>Psychology</b> <input type="checkbox"/> Normal <input type="checkbox"/> feeling sad <input type="checkbox"/> feels upset easily <input type="checkbox"/> outburst of temper <input type="checkbox"/> feels hopeless <input type="checkbox"/> behavior issues/problems <input type="checkbox"/> anxiety <input type="checkbox"/> ideas of hurting self and others If so, for how long? If so, who? <input type="checkbox"/> Other: _____	<b>Neurology</b> <input type="checkbox"/> Normal <input type="checkbox"/> developmental delay <input type="checkbox"/> headaches <input type="checkbox"/> seizures <input type="checkbox"/> dizziness <input type="checkbox"/> fainting <input type="checkbox"/> abnormal movements <input type="checkbox"/> tremors <input type="checkbox"/> tingling <input type="checkbox"/> numbness <input type="checkbox"/> decreased sensation <input type="checkbox"/> Other: _____
<b>Blood circulation</b> <input type="checkbox"/> Normal <input type="checkbox"/> anemia <input type="checkbox"/> received blood products <input type="checkbox"/> easy bruising <input type="checkbox"/> bleeding disorder <input type="checkbox"/> Other: _____	<b>Immunology</b> <input type="checkbox"/> Normal <input type="checkbox"/> Allergies <input type="checkbox"/> Frequent infections <input type="checkbox"/> Unusual infections <input type="checkbox"/> swollen lymph node <input type="checkbox"/> Other: _____	

**Social History:**

**Who all lives with the patient at home? (Please check all that apply)**

- Both parents     Mother     Father     Step-father     Step-mother     Foster parents  
 Grandmother     Grandfather     Sibling(s)     Aunt(s)     Uncle(s)     Significant other of parent  
 Youth Home (If yes, how long? \_\_\_\_\_ what is the reason? \_\_\_\_\_)

**Parental Status**

- Married     Single     Divorced     Separated     Unmarried     Dual parenting

**Patient's Sexual History**

- Not applicable     Not currently sexually active     Never sexually active  
 Sexually active    (If yes, does patient use protection?  No     Yes)  
     If active, how many partners?     Single     Multiple

**Does the patient use alcohol?**     No     Yes (If yes, please answer the following questions).

How much does the patient drink per week?     1-2 drinks     3-4 drinks     5+ drinks

**Does the patient use tobacco?**     No     Yes (If yes please, answer the following questions).

What type of tobacco?     Cigarettes     Cigars     Chewing     Snuff     Hookah

How often per week?     1-2 times     3-4 times     5+ times

If the patient smokes cigarettes, how many per day?

1-2 cigarettes     3-4 cigarettes     5-6 cigarettes     half a pack     full pack

**Does the patient use marijuana?**     No     Yes (If yes please, answer the following questions).

How often per week?     1-2 times     3-4 times     5+ times

**Does the patient have any pets?**

dog(s)     cat(s)     fish(es)     other (please specify) \_\_\_\_\_

**Does the patient attend school?**     No     Yes (If yes, please answer the following questions).

What school grade is the patient in? \_\_\_\_\_

What type of grades does the patient get?     A's     B's     C's     D's     F's

If applicable, what is the patient's GPA? \_\_\_\_\_

**Does the patient attend daycare?**     No     Yes

**What does the patient want to be when he/she grows up?** \_\_\_\_\_

**What type(s) of sports does the patient participate in?**

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**Please list the hobbies that the patient enjoys?**

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**Social Neglect:**

Do you believe your child is abused or neglected in any way to your knowledge?     No     Yes

If yes, please explain: \_\_\_\_\_

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**Diet History:**

<b>If your child is an infant/toddler, please answer the following questions:</b>	<b>If your child is older than a toddler, please answer the following questions:</b>
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<p>Is your child currently being breastfed?  <input type="checkbox"/> No   <input type="checkbox"/> Yes</p> <p>If breastfed, how many feedings per day? _____</p> <p>Is there supplementation with formula?  <input type="checkbox"/> No   <input type="checkbox"/> Yes</p> <p>If not breastfed, what type of formula? _____</p> <p>How frequent are feedings?  <input type="checkbox"/> 2 hr   <input type="checkbox"/> 3 hrs   <input type="checkbox"/> 4 hrs   <input type="checkbox"/> 6 hrs</p> <p>Are you adding cereal to the formula? <input type="checkbox"/> No   <input type="checkbox"/> Yes</p> <p>If yes, how many teaspoons of cereal to each bottle?  <input type="checkbox"/> 1   <input type="checkbox"/> 2   <input type="checkbox"/> 3   <input type="checkbox"/> 4   <input type="checkbox"/> 5+</p> <p>Other foods: _____</p> <p><input type="checkbox"/> Stage I baby food  <input type="checkbox"/> Stage II baby food</p>	<p>How many servings of milk per day? _____</p> <p>What type of milk? <input type="checkbox"/> 1%   <input type="checkbox"/> 2%   <input type="checkbox"/> Whole milk</p> <p>How many servings of vegetables per day? _____</p> <p>How many servings of fruits per day? _____</p> <p>How many cups of juice per day? _____</p> <p>Does your child consume spicy foods? <input type="checkbox"/> No   <input type="checkbox"/> Yes</p> <p>Does your child have diet restrictions? <input type="checkbox"/> No   <input type="checkbox"/> Yes</p> <p>If yes, please explain: _____</p> <p>_____</p> <p>_____</p>
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**Development:**

Based on your own understanding, is your child's development:

- Normal                       Delayed (If yes, what is the determined developmental age? \_\_\_\_\_)
- Being investigated       Other (please, specify): \_\_\_\_\_

**Please tell us anything else that you think may be important for us to know about your child.**

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**Please let us know what your child would want to know from this visit.**

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What are his/her concerns?

- Fear of clinic       Fear of doctor       Fear of needles       Other: \_\_\_\_\_

What are your concerns? \_\_\_\_\_

**Parent Signature:** \_\_\_\_\_      **Date:** \_\_\_\_\_