



PROGRESSIVE
CHILD & ADOLESCENT
GASTROENTEROLOGY

Welcome to Progressive Child & Adolescent Gastroenterology
New Patient Questionnaire for Failure to Thrive

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: _____

Slow Weight Gain/Failure to Thrive

When did this start? Since birth 2-3 months 6-8 months 1 year Other: _____

What was done for this? _____ What did doctor do? _____

Any ER visits: No Yes

Any Hospital admissions: No Yes (If yes, please answer the next questions).

If yes, for how long? _____ If yes, what was done? _____

If yes, did it help? No Yes

Does the patient have a normal appetite? No Yes

Is your child a picky eater? No Yes

Does your child refuse to eat? No Yes (If yes, please answer the next questions).

If yes, does your child turn head away? No Yes

If yes, does your child thrust tongue out? No Yes

If yes, does your child get mad seeing eating utensils (spoon, fork)? No Yes

If yes, does your child vomit at sight of food? No Yes

Does your child make an extra effort to swallow? No Yes

What is the pattern of weight gain? Very slow Erratic Gains & Loses None

What are the associated symptoms?

Vomiting Diarrhea Constipation Abdominal distention

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?
Drugs <input type="checkbox"/> No <input type="checkbox"/> Yes		
Foods <input type="checkbox"/> No <input type="checkbox"/> Yes		
Other		

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>General <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>Skin <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>Eyes <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>
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Ears, Nose, & Throat <input type="checkbox"/> Normal <input type="checkbox"/> hearing loss <input type="checkbox"/> ear pain <input type="checkbox"/> ear infections <input type="checkbox"/> nose bleeds <input type="checkbox"/> sinus infections <input type="checkbox"/> sleep apnea <input type="checkbox"/> trouble swallowing <input type="checkbox"/> tooth decay <input type="checkbox"/> mouth sores <input type="checkbox"/> hoarseness <input type="checkbox"/> Other: _____	Respiratory <input type="checkbox"/> Normal <input type="checkbox"/> wheezing <input type="checkbox"/> asthma <input type="checkbox"/> persistent coughing <input type="checkbox"/> shortness of breath with unusual exertion <input type="checkbox"/> shortness of breath for no reason <input type="checkbox"/> pneumonia <input type="checkbox"/> Other: _____	Endocrine <input type="checkbox"/> Normal <input type="checkbox"/> weakness/tired <input type="checkbox"/> hyperactive <input type="checkbox"/> hot sensitivity <input type="checkbox"/> cold sensitivity <input type="checkbox"/> increased frequency or amount of urine <input type="checkbox"/> menstrual irregularity <input type="checkbox"/> poor growth -Age when periods started ____ -Cycles <input type="checkbox"/> Regular <input type="checkbox"/> Irregular <input type="checkbox"/> Other: _____
Urinary System <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: _____	Gastrointestinal <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: _____	Cardiovascular <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: _____
Musculoskeletal <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: _____	Psychology <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: _____	Neurology <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: _____
Blood circulation <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: _____	Immunology <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?

Please list the hobbies that the patient enjoys?

Social Neglect:

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

If yes, please explain:

Diet History:

If your child is an infant/toddler, please answer the following questions:	If your child is older than a toddler, please answer the following questions:
<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> <hr/> <hr/>

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.

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

What are his/her concerns?

- Fear of clinic Fear of doctor Fear of needles Other: _____

Parent Signature: _____ **Date:** _____