



**PROGRESSIVE
CHILD & ADOLESCENT
GASTROENTEROLOGY**

**Welcome to Progressive Child & Adolescent Gastroenterology
Second Opinion Consultation Questionnaire**

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:** _____

Symptom/Condition for which second opinion is being sought: _____

List two main concerns: _____

List two main expectations: _____

Is your child presently in school: Yes No

If not, how long they are out of school: _____

Is your child being home schooled: Yes No

Online School: Yes No

How long has the main problem been going on ?

2 weeks 1-2 months 3-4 months 5-7 months 10-12 month Other: _____

List previous treatments:

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?
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 were 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 <input type="checkbox"/> fever <input type="checkbox"/> excessive sweating <input type="checkbox"/> fatigue/tired <input type="checkbox"/> exercise intolerance <input type="checkbox"/> Other: _____</p>	<p>Skin <input type="checkbox"/> Normal <input type="checkbox"/> eczema <input type="checkbox"/> dry skin <input type="checkbox"/> acne <input type="checkbox"/> bruising <input type="checkbox"/> hair loss <input type="checkbox"/> itching <input type="checkbox"/> jaundice <input type="checkbox"/> diaper rash <input type="checkbox"/> Other: _____</p>	<p>Eyes <input type="checkbox"/> Normal <input type="checkbox"/> glasses <input type="checkbox"/> contact lenses <input type="checkbox"/> light sensitivity <input type="checkbox"/> pink eye <input type="checkbox"/> discharge <input type="checkbox"/> itching of eyes <input type="checkbox"/> Other: _____</p>
<p>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: _____</p>	<p>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: _____</p>	<p>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: _____</p>
<p>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: _____</p>	<p>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: _____</p>	<p>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: _____</p>

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

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: _____

What are your concerns? _____

Parent Signature: _____ **Date:** _____