PROGRESSIVE
CHILD & ADOLESCENT
GASTROENTEROLOGY

Welcome to Progressive Child & Adolescent Gastroenterology

New Patient Questionnaire for Vomiting

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:**_____

How long has this been a problem? ☐ 2 weeks ☐1-2 months ☐3-4 months ☐5-7 months ☐10-12 month ☐ Other: _____

How many times per day? ☐ 1-2 ☐ 3-4 ☐ 5-6 ☐7-8 ☐ 10+

What makes it worse? ☐ Eating foods ☐ Smell ☐ Frustration ☐Stress

What is the amount of vomit? ☐ Small (spit-ups) ☐Moderate ($^1/_2$ of eaten foods) ☐ Large (all foods eaten)

What is the color of the vomit? ☐ Clear ☐Food ☐Red ☐Green ☐Yellow

Is there abdominal pain associated with vomiting? ☐ No ☐ Yes (If yes, answer the next question)

If yes, does vomiting relieve pain? ☐ No ☐ Yes

Is there a time of day when vomiting is worse?

☐ Early morning ☐ At school ☐ After meals ☐ Before bedtime

Are there any other symptoms associated with this? _____

For infants:

Is the vomiting forceful? ☐ No ☐ Yes

Is there weight loss? ☐ No ☐ Yes (If yes, answer the next questions)

If yes, how much in lbs? _____ In what duration of time? _____

Did you add infant cereal to the formula? ☐ No ☐ Yes (If yes, answer the next questions)

How much cereal added to formula? ☐ 1-2 teaspoons ☐ 2-3 teaspoons ☐ 3+ teaspoons

Effect of adding infant cereal to formula: ☐ Helpful ☐ No change ☐ Worsened vomiting

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 ☐ No ☐Yes		
Foods ☐No ☐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 Chough ☐ 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 enterocoliis 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.

☐ Asthma	☐ Childhood death	☐ High blood pressure
☐ Celiac disease	☐ Crohn's Disease	☐ Acid reflux
☐ Constipation	☐ Colon Cancer	☐ Chronic diarrhea
☐ Hirschsprung's Disease	☐ Gallstones	☐ Pancreatitis
☐ Stomach ulcers	☐ Irritable Bowl Syndrome	☐ Lactose intolerance
☐ Polyps	☐Ulcerative Colitis	☐ Liver Disease
☐ Thyroid Disease	☐ Jaundice	☐ Hepatitis
☐ Cirrhosis	☐ Cystic Fibrosis	☐ Anemia

☐Other (Please specify)_____

Review of Systems

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

General ☐Normal ☐fever ☐excessive sweating ☐fatigue/tired ☐exercise intolerance ☐Other:_____	**Skin** ☐Normal ☐eczema ☐dry skin ☐acne ☐bruising ☐hair loss ☐itching ☐jaundice ☐diaper rash ☐Other: _____	**Eyes** ☐Normal ☐glasses ☐contact lenses ☐light sensitivity ☐pink eye ☐discharge ☐itching of eyes ☐Other: _____

Ears, Nose, & Throat ☐Normal ☐hearing loss ☐ear pain ☐ear infections ☐nose bleeds ☐sinus infections ☐sleep apnea ☐trouble swallowing ☐tooth decay ☐mouth sores ☐hoarseness ☐Other: _____	**Respiratory** ☐ Normal ☐wheezing ☐asthma ☐persistent coughing ☐shortness of breath with unusual exertion ☐shortness of breath for no reason ☐pneumonia ☐Other: _____	**Endocrine** ☐Normal ☐weakness/tired ☐hyperactive ☐hot sensitivity ☐cold sensitivity ☐increased frequency or amount of urine ☐menstrual irregularity ☐poor growth **-Age when periods started ____** **-Cycles** ☐Regular ☐Irregular ☐Other:_____
Urinary System ☐ Normal ☐kidney failure ☐pain/burning with urination ☐increased frequency or amount of urine ☐swelling/retaining water ☐urinary tract infection ☐bedwetting ☐day time wetting ☐Other: _____	**Gastrointestinal** ☐Normal ☐trouble with bowel movement/constipation ☐diarrhea ☐nausea/vomiting ☐excess weight gain ☐weight loss, how much _____ ☐poor appetite ☐excessive appetite ☐gassiness ☐burping ☐feeling full after a small amount ☐rectal bleeding ☐Other: _____	**Cardiovascular** ☐Normal ☐chest pain ☐palpitations ☐heart beats fast for no reason ☐fainting ☐heart murmur ☐congenital heart disease ☐heart surgery ☐hypertension ☐Other: _____
Musculoskeletal ☐Normal ☐bone problems ☐scoliosis ☐joint problems ☐muscle pain ☐mobility issues ☐loose joints ☐increased flexible ☐Other:_____	**Psychology** ☐ Normal ☐feeling sad ☐feels upset easily ☐outburst of temper ☐feels hopeless ☐behavior issues/problems ☐anxiety ☐ideas of hurting self and others If so, for how long? If so, who? ☐Other:_____	**Neurology** ☐Normal ☐developmental delay ☐headaches ☐seizures ☐dizziness ☐fainting ☐abnormal movements ☐tremors ☐tingling ☐numbness ☐decreased sensation ☐Other:_____
Blood circulation ☐ Normal ☐anemia ☐received blood products ☐easy bruising ☐bleeding disorder ☐Other: _____	**Immunology** ☐Normal ☐Allergies ☐Frequent infections ☐Unusual infections ☐swollen lymph node ☐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 ☐3-4cigarettes ☐ 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? ☐ No ☐Yes If breastfed, how many feedings per day? _____ Is there supplementation with formula? ☐No ☐Yes If not breastfed, what type of formula? _____ How frequent are feedings? ☐2 hr ☐3 hrs ☐4 hrs ☐6 hrs Are you adding cereal to the formula? ☐ No ☐Yes If yes, how many teaspoons of cereal to each bottle? ☐1 ☐2 ☐3 ☐4 ☐5+ Other foods: _____ ☐ Stage I baby food ☐ Stage II baby food	How many servings of milk per day? _____ What type of milk? ☐1% ☐2% ☐ 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? ☐No ☐Yes Does your child have diet restrictions? ☐No ☐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: _____

Parent Signature: _____ Date:_____